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CONTENTS AND SUBJECT INDEX

Some of the Preventive Aspects of the Mental Health Problem: Chairman's Address. H. R. Casparis, M.D., Nashville, Tenn.....2207

Prognosis in Gallbladder Surgery. William D. Wilson, M.D., Rochester, Minn.; Edwin P. Lehman, M.D., and William H. Goodwin, M.D., University, Va.....2209

Diabetes Mellitus Among Ex-Service Men. Philip B. Matz, M.D., Washington, D. C.....2214

Duration of Sperm Cell Migration in Uterine Secretions. William H. Cary, M.D., New York.....2221

Variations in Bile Pressure in the Human Biliary Tract. Harold A. Kipp, M.D., Pittsburgh.....2223

Pressure in the Common Bile Duct of Man. J. M. McGowan, M.D.; Winfield L. Butsch, M.D., and Waltman Walters, M.D., Rochester, Minn.....2227

Stomatitis Due to Sensitization to Dental Plates. Herbert Rattner, M.D., Chicago.....2230

Perineal Testicle. Meredith F. Campbell, M.D., New York...2232

Heredity and Cancer. C. C. Little, Sc.D., Bar Harbor, Maine....2234

CLINICAL NOTES, SUGGESTIONS AND NEW INSTRUMENTS

Contact Dermatitis Produced at a Distance. Joseph B. Biederman, M.D., Cincinnati.....2236

Traumatic Deltoid Paralysis Treated by Muscle Transplantation. William Donald Davidson, M.D., Evansville, Ind.....2237

Paroxysmal Auricular Fibrillation After Permanent Relief of Hyperthyroidism. Ernst P. Boas, M.D., New York.....2238

Streptococcic Meningitis. S. W. Marick, M.D., Pittsburgh.....2238

COUNCIL ON PHARMACY AND CHEMISTRY 2239

EDITORIALS

Urinary Histidine in the Diagnosis of Pregnancy.....2240

Hemolytic Shock After Blood Transfusion 2241

Septicemia Due to Anaerobic Organisms 2242

CURRENT COMMENT

Pressure in Common Duct and Relief of Pain Following Cholecystectomy 2242

BUREAU OF LEGAL MEDICINE AND LEGISLATION 2260

(Subject Index on next page)

INDEX

List of Journals Indexed.....2269

Semiannual Index to Reading Matter in The Journal and to Current Medical Literature.....2271

Index to Authors.....2320

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Further details in SAUNDERS ADVERTISEMENT—Page 3

SUBJECT INDEX TO THIS ISSUE

The letters used to explain in which department the matter indexed appears are as follows: The Star (*) indicates an Original Article; "ab," abstract; "E," Editorial; "C," Correspondence; "Ml," Medicolegal; "ME," Medical Economics.

A. M. A., President Mason, death....2252
Anemia, Pernicious, painful tongue....2256
Angina, agranulocytic....ab-2268
Army, U. S., examination for Medical Corps....2246
Arthritis, parathyroidectomy in ankylosing polyarthritis....ab-2268
Auricular Fibrillation with apoplexy....ab-2262
paroxysmal, after thyroidectomy....*2238
Bile Duct, pressure in....*2227; E-2242
Birth Control, National Medical Council on,....2246
Blood changes after exertion at high altitudes....ab-2266
coagulation, physiology....2249
transfusion, hemolytic shock after....E-2241
Board Examinations....2257
Book Notices....2258
Books Received....Adv. Page 25
Breast, gynecomasty....ab-2268
Bureau of Legal Medicine and Legislation..2260
Camps, diets for boys in....2254
Cancer, heredity....*2234
Chicago Medical Society....2243
Children, behavior....*2208
Climate, mountain, as therapeutic factor..ab-2266
Colon, surgery....2251
Concrete industry, hazards....2255
Congress, U. S., medical bills in....2246
Corpus Luteum cyst, ruptured, massive abdominal hemorrhage from....ab-2264
Correspondence....2253
Council on Pharmacy and Chemistry....2239
Deaths....2252
Diabetes Mellitus, burns as cause....2256
in ex-service men....*2214
Diphtheria immunization, compulsory....2249
incidence, France....2249
with scarlet fever....C-2253
Dyspnea, cardiac, mercurial diuretics for..ab-2263
Eclampsia, dosage of chloral in....2256
Embolism, air, cause of death in....ab-2267
Endocarditis, acute, due to Pfeiffer's bacillus....2248
Epilepsy, lift reaction as aura in....ab-2267
Fees, schedule, Italy....2251
Fever, hyperthermic syndrome (postoperative) in infants....ab-2266
Food poisoning from mold on bread?....2256
Foreign Letters....2247
French Information Center....2246
Gallbladder calculi, genesis....ab-2263
pain after cholecystectomy....*2227; E-2242
surgery, prognosis....*2209
Gangrene, gas, surgical prevention....ab-2264
Gargles, inefficiency....C-2253
Gasoline, contact dermatitis produced at a distance by....*2236
Glasses, reduction of glare in....2254
Government Services....2246
Growth, delayed, treatment....2255
Hall, Maurice C....2246
Health, *Connecticut Health Bulletin*, 50th anniversary....2243
department expansion, Connecticut....2243
units, new, Florida....2243
Hemorrhage, control in nose and throat operations....ab-2265
control by congo red....ab-2263
Heredity, Bureau of Human Heredity....2247
Hospitals, bequests and donations....2246
Immunization, multiple....2255
Infectious Disease, prophylaxis, France....2249
Insurance, health, societies, statistics, Germany....2250
freedom of choice of physician....2251
International Medical Week....2246
Intestine, large, surgery....2251
Keratitis, phlyctenular, etiology....2248
Kerosene, deodorized; where obtainable....2256
Lambotte, Albin, jubilee book honoring...2246
Leukemia, laboratory observations in...ab-2261
Lung, cancer, primary....ab-2270
surgery vs. vagus....ab-2262
Marriages....2251
Measles, prophylaxis, France....2249
Medical Examinations and Licensure....2257
Medicolegal Abstracts....2260
Meek, W. J., gives Luckhardt Lecture....2243
Meetings, Coming Meetings....2260
Meningitis, cerebrospinal, France....2249
lymphocytic, virus etiology....ab-2265
streptococcic, recovery....*2238
Mental Health, preventive aspects....*2207
Milk, official grading, England....2247
Muscles, disorders, aminoacetic acid for..ab-2261
Myeloma, multiple, sternal puncture diagnosis....ab-2267
Myositis, traumatic ossifying, after elbow dislocation....ab-2267
New and Nonofficial Remedies....2239
News....2243
Optometry Practice Acts: licenses; revocation; hearings, sufficiency of notice.Ml-2260
Paralysis, traumatic deltoid, muscle transplantation for....*2237
Park, W. H., to retire....2245
Peptic Ulcer, postanastomotic....2251
Peritoneum, sodium chloride irrigation...2256
Physicians, problems, Italy....2251
Pneumococci, typing by Neufeld reaction.ab-2261
Poliomyelitis, in France....2249
spinal fluid test....2254
Pregnancy, diagnosis, histidine in urine.E-2240
Pulse, venous, of extremities....ab-2267
Queries and Minor Notes....2254
Race, problem, Huxley's address....2247
Radiology in medical curriculum....2248
Reticuloplasmocytomas, iliosacral....ab-2268
Rush Medical College....2243
Scarlet Fever, diphtheria with....C-2253
Septicemia due to anaerobic organisms...E-2242
Silicosis: not an occupational disease...Ml-2260
Smallpox, outbreak, Illinois....2243
prophylaxis, France....2249
Societies, county, and medical economics..2244
Society Proceedings....2260
Spermatozoa, factors affecting viability....2256
migration in uterine secretions....*2221
Splenectomy, blood picture after....ab-2261
Sprains....ab-2265
Staphylococcus, food poisoning....2256
State Board Examinations....2257
Strains....ab-2265
Surgery, Società Piemontese di chirurgia..2251
Syphilis, treatment....2254
Tax, income, and birth rate, England....2247
Teeth, stomatitis from plates....*2230
Testis, perineal....*2232
Thorax cavity, tubing for drainage....C-2253
Throat irrigation by gargles....C-2253
Thyroidectomy, subtotal, paroxysmal auricular fibrillation after....*2238
Tongue, painful....2256
Tonics and Sedatives....Adv. Page 20
Tuberculosis death rate lowered, Calif....2243
development vs. influenza....2251
pulmonary, bilateral cavernous....ab-2262
pulmonary, monocyte-lymphocyte ratio ab-2266
Undulant Fever, danger of vaccination with living vaccines....2248
prophylaxis, in France....2249
Uterus, sperm cell migration in secretions.*2221
Veterans, diabetes in ex-service men....*2214
Vomiting, antiemetic combination....2256
Whooping Cough, immunization....2255

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SOME OF THE PREVENTIVE ASPECTS OF THE MENTAL HEALTH PROBLEM

CHAIRMAN'S ADDRESS

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NASHVILLE, TENN.

During the past two or three decades, as modern psychiatry has been developed in this country under the leadership of Dr. Adolf Meyer, there has gradually appeared a broader and broader realization of the importance of mental health. The differentiation of functional mental disorders from organic mental disorders, the improved facilities in medical schools for teaching psychiatry, the training of private practitioners and the establishment of clinics and institutions for carrying out the improved methods of diagnosis and treatment have all contributed to a wide stimulation of interest in the subject of mental health. Also, these developments have brought a better understanding of the whole problem and have indicated its immensity. For example it is said that the majority of the hospital beds in the United States are occupied by individuals who are there because of mental disorders. This is rather appalling, especially if we pause and recall how many there are of us who are still ambulatory.

With this huge problem before us and with the rather wide recognition of its importance it seems that the time is ripe to begin to direct more attention toward the preventive aspects of poor mental health than we have in the past. It is not meant by this that psychiatrists have not been actively concerned with prevention, but the incidence of mental disease is so great that they have been more or less swamped with mental problems already developed. In that they have attempted to prevent less serious problems from becoming more serious ones, of course they have practiced prevention in the broader sense. Even a further step in the direction of prevention has been made chiefly by the psychiatrists, and that is that mental hygiene and child guidance clinics have been established. However, the attendance at these clinics is made up almost entirely of children who already have well developed problem difficulties. My purpose then in this discussion is to emphasize the importance of beginning preventive work before mental problems develop, to try to point out how it can be done, and to indicate where the chief responsibility for its accomplishment lies.

But, before proceeding directly into the discussion of prevention, it might be well to recall that there has been a great deal of criticism by the medical profession directed at certain trends in mental health work. Since almost every adult considers himself thoroughly capable of training children along ideal lines, and since the medical profession has to a large extent failed to assume the responsibility for giving information concerning this important procedure, quite naturally a number of individuals, even though inadequately trained, have entered this field. Some have gone in because of sentimental reasons. There are others who have been cheated out of the opportunity to train children and find in the child guidance clinic an opportunity for personal satisfaction and heavenly contentment. The foregoing is offered as an explanation for some of the critical remarks from the medical profession and is in no sense meant as a criticism of the well trained workers in this field whose accomplishments are commendable. We medical men like others have some tendency to criticize those who take over our responsibilities, even if we make little effort to assume them ourselves; but on our side we should not be blamed too severely for not taking over this work, since the medical schools have been at fault in not teaching us adequately concerning the various aspects of mental health work, especially the preventive aspects.

The realization that mental health is quite as important as physical health, that the two are undissociable and together concern the everyday activity of the whole human being, is gradually taking root. It is further being realized, since the two are equally important and undissociable, that the individual potentially best qualified to assume the responsibility for the health of this whole human being is the physician himself. If prevention is going to play the important rôle in mental health that it has in physical health, and there is no reason why it should not, we should begin practicing preventive measures as near the beginning as possible, since we have found that that early start is so effective in the prevention of poor physical health. It therefore follows that those who are going to be chiefly concerned with these activities are the pediatricians and other physicians who have the opportunity to supervise the care of the child from the beginning.

Let us return now to some of the practical aspects of prevention. If we begin by using the familiar term "health" instead of "hygiene," when thinking of mental functions, which places mental health on the same plane as physical health, and if we think of a human being in action in terms of behavior rather than in terms of mentality, I think we might be able to wean ourselves from much of the confusion that exists or has been created. If we eliminate the word "normal" and substitute the word "adequate," I think we shall be on much firmer foundation. And, if we will only recall that there are certain familiar common sense laws and principles which have guided human beings to and through an adequate existence ever since there have been human beings; that these simple basic laws have

From the Department of Pediatrics, Vanderbilt University Medical School.

Read before the Section on Pediatrics at the Eighty-Seventh Annual Session of the American Medical Association, Kansas City, Mo., May 13, 1936.

never changed and never will change; that we may group them under the head of religion, philosophy of life, common sense, or what you will, then shall we realize that any and all of us are capable of taking part in this work.

Going a step further, the task will be simpler if we recall that there is no fundamental difference mentally between human beings at any age. Infants differ from adults only in that adults through experience have learned to behave differently from children. In other words, child psychology is nothing more or less than human psychology. Psychology is that branch of science which concerns itself with the study of the mind or mental reactions. Mental reactions constitute our behavior. Behavior is the manner in which all of us spend our time, and all of us, regardless of age, spend all our time trying to get what we want (or that which produces comfort and pleasure), and trying to avoid what we do not want (or that which produces discomfort and displeasure).

Beginning then with the new-born infant, let us see if we cannot indicate briefly how adequate human beings are built. In the first place, the building material varies. In other words, no two infants start with the same hook-up, endowment or inheritance. We do not have to know immediately what the quality of this material is, since we are familiar with the plan of building. We must, however, recognize as nearly as possible as we go along whether we are getting the best out of our building material, and also that we are not trying to build a stronger mental structure than the material permits. The load must not be unbearable. The recognition then that the initial material out of which we try to build adequately functioning human beings varies tremendously in quality is about all we can do about inheritance.

With regard to environment, we first and continually consider our material and, as already outlined, build as well as we can with that particular material. To do this we must pay as careful attention to mental nutrition as we do to physical nutrition, for unless human beings are mentally well nourished we cannot expect them to develop into adequately behaving human beings. Mental nutrition is made up largely of the satisfaction of accomplishment commensurate with one's ability to accomplish. If we at any stage push any one too long beyond his ability to accomplish, disaster follows. Apply this to almost any phase of activity in life and it will readily be seen where the root of much of our trouble lies. On the contrary, if one accomplishes more or less commensurate with one's ability to accomplish, we usually see in that individual a stimulation to go ahead, sustained morale, self respect and at least much of the make-up of ambition.

Another human quality which is one of our main stays in respect to adequacy is courage. What are some of the elements which we commonly recognize as components ofcourage? Of course some human beings are born with more of this quality than others, but we may say simply that life is made up of a rough and a smooth side, a pleasant and an unpleasant side. We are apt to call any individual who faces the rough side with his chin out as well as who enjoys the smooth side a courageous individual. How then may we train the child to be courageous? From the very beginning it is important that he recognize that there is the unpleasant as well as the pleasant. His reaction to the unpleasant from the beginning is apt to be crying. This is natural, since it is his only mode of expressing displeasure or discomfort. Infants soon learn to enjoy affection, sympathy and attention just as all human beings do, and if when he cries these are bestowed on him he quickly learns to use crying to get them. If, on the other hand, when he cries these are withheld and only necessary attention is given calmly, and one holds back affection, sympathy and undue attention until he is pleasant and behaving nicely, he soon learns that that is the way to get these things. He thus adopts this method of accomplishment which he has found successful and he becomes a pleasant, attractive individual. Parents through their sentimentality and self indulgence find it difficult to carry out these practices, but if persisted in they will succeed in preventing a child from being a whining, crying, pouting and tantrum-throwing individual. In other words, he soon learns to face his difficulties more or less pleasantly and is called a brave or courageous child. Remember that we adults cry after our fashion just as children do if we have not learned to face our difficulties with equanimity. The only difference is that our crying does not usually sound the same as that of a child. Instead, we swear, complain and offer alibis for our failures. In brief, we can train children from the beginning to face the rough side of life as well as enjoy the smooth side and thereby save many older children and adults from many of their neurotic tendencies, nervous breakdowns and suicidal tendencies.

Time and space do not permit me to discuss in detail many of the phases of behavior which go to make up everyday conduct. It might be well, however, merely to mention the matter of the amount of energy healthy children have, since it plays such a prominent part in our attitude toward them. Too often in our care of children we try to smother their normal, wholesome energy simply because its intensity worries us adults. The healthy energy of a child may be compared with the familiar electrical energy. We do not dare try to stop electrical energy but we may direct it along wholesome lines and accomplish remarkable things. This applies to the energy of children. It is not meant by this that we do not say "no" to children, for we can always say "no" reasonably, fairly and honestly to a child and demand obedience when he is doing that which is dangerous to himself or others, when he is destructive of valuable things, when he is interfering with the rights of others, and when he is making any unreasonable demands. If time permitted to elaborate it would be seen that these same "noes" reasonably apply to adults also, except that adults are supposed to have reached the age of discretion and may do things that are dangerous to themselves without interference.

Further, children should be treated always as if they were older than they are, one should have confidence in them, even though they may make mistakes or not always do things as we think they should, for it should be remembered that we ourselves blundered along and some one was kind enough to encourage us and permit us to live in spite of our mistakes and failures. Encouragement should be given for worth-while accomplishments even though they appear quite insignificant. Worth-while accomplishments are those that are good commensurate with the child's ability to perform. Children should be made responsible members of the family according to their ability to assume responsibilities, even though small, and should never be thought of merely as attachments to the family who are there to be told what to do and what not to do. If there is only one child in a family of three he should get the impression

that he is only a third of the family, and the smallest third, rather than seven eighths of it. This is difficult, but important for his sake.

One could go further and explain the basis for lying, stealing, reliability, dependability and how to make children mind, through all the elements that go to make up our everyday behavior, but the point of this discussion is to try to emphasize that the indications and methods for constructing mentally adequate older human beings out of infants and children are specific and definite. Knowing what to do in any given situation is not difficult, for it is just what an adult would consider the fair procedure for himself under fundamentally similar circumstances. All answers should be based on the age-old simple common sense laws that are conducive to adequate human conduct. But getting it done is often extremely difficult, for varying degrees of sentiment interfere and too frequently distort our views and warp our decisions.

Finally, there is great need and even a rapidly increasing demand from laymen for information concerning the preventive aspects of the mental health problem, and it is the responsibility of those of us physicians who care for children from the beginning to prepare ourselves to give it. Psychiatrists should help teach us and are certainly indispensable in helping us solve the more serious problems. Medical schools must emphasize prevention in their teaching as well as teach diagnosis and treatment of mental disease. The mental health problem in all of its aspects, then, is our combined responsibility and is not the property of any particular group.

PROGNOSIS IN GALLBLADDER SURGERY

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EDWIN P. LEHMAN, M.D.
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Recognition of the deficiencies of gallbladder surgery from the point of view of complete relief of symptoms has troubled both surgeons and internists. It is generally agreed that, although the place of surgery in the treatment of a large group of patients with gallbladder disease is established, in another group the benefits of surgery are not so obvious. Many clinics have attempted to determine the criteria that place the individual patient in one or the other group. The method usually employed has been statistical in nature, consisting of analyses of clinical results as related to variations in history, physical examination and laboratory data.

Conclusions from current literature may be broadly generalized. Three criteria have received particular attention. Observers are in unanimous agreement that the patient with cholelithiasis has a better chance for relief of symptoms than the patient who has no stones. This contrast has been ascribed to the greater violence of symptoms in the former instance, either offering an opportunity for relatively greater relief of symptoms or affording a more accurate diagnosis. As a corollary it is felt that the more severe the symptoms the more probable the relief. The third contention is much less completely accepted and is the most widely discussed element in gallbladder surgery at present. The opinion is apparently gaining ground that the nearer the time of operation to the onset of the acute attack, the better the prognosis for operative recovery and symptomatic cure.

The present paper consists of an analysis of 610 consecutive cases of cholecystitis and cholelithiasis studied along conventional lines. In addition an attempt has been made to assay the significance of results by the use of statistical formulas. The final aim in the analysis has been to throw light on criteria that may offer a prognosis in the individual case.

MATERIAL

The 610 cases of gallbladder disease were treated at the University of Virginia Hospital by operation at the hands of twenty surgeons during the years 1921 to 1934. Twenty-two of the patients died in the hospital, a mortality rate of 3.6 per cent as compared to a rate of 5.8 per cent in 512 cases reported from this hospital in 1921 by Goodwin.[1] Cases of carcinoma in or near the gallbladder are not included.

Written replies to a questionnaire or visits to the clinic afforded an estimate of final results in 447 cases (76 per cent) at intervals following treatment of from four months to thirteen years. The patients were questioned concerning (1) general health, (2) recurrence of symptoms, (3) food tolerance, (4) hernia, (5) capacity for work and (6) their estimate of the effects of treatment. These replies were first graded as follows:

GRADE 1. *Excellent Result.*—General health good; no recurrence of symptoms; no diet idiosyncrasy; no hernia or weakness of the operative wound; patient able to do ordinary work. The patients ascribe their freedom from symptoms to the operation.

GRADE 2. *Good Result.*—General health good; mild digestive symptoms or a few foods not well tolerated; no hernia; patient able to do ordinary work. The patients ascribe their great improvement to operation.

GRADE 3. *Fair Result.*—General health fair; bothersome digestive symptoms or occasional pain in the right upper quadrant; no hernia; patient usually able to do ordinary work. The patients believe themselves improved by operation. Many of the patients in this group are in fact but slightly discommoded by their symptoms and none are incapacitated.

GRADE 4. *Poor Result.*—General health poor, colic or frequent and marked indigestion; hernia; unable to do ordinary work. The patients consider themselves unimproved or made worse by operation. It must be noted that patients are placed in this group who present one of the unfavorable manifestations, although a few had several of them.

For simplification, the cases in groups 1 (excellent) and 2 (good), together with cases in which deaths were reported from other causes and in which there was no recurrence of gallbladder symptoms, are grouped together as "satisfactory results." The cases in groups 3 and 4, together with the deaths from any cause in which a recurrence of gallbladder symptoms had been reported, are grouped as "unsatisfactory results." This simple grouping definitely tends to minimize the value of surgery in gallbladder disease, since many patients in group 3 were well satisfied with the outcome of treatment. The really bad results are few in number. If one was to combine groups 1, 2 and 3 as "satisfactory results," a grouping for which there would be some justification, the percentage of satisfactory results would be 91.3 per cent as compared to 74.3 per cent in the present grouping.

From the Department of Surgery and Gynecology and the University Hospital, University of Virginia School of Medicine, University, Va.

1. Goodwin, W. H.: The Surgery of the Gallbladder, with an Analysis of Five Hundred and Twelve Cases, South. M. J. **15**: 712 (Sept.) 1922.

METHODS OF ANALYSIS

The data have been analyzed by the usual comparisons of percentages. Age, sex, race, duration and severity of symptoms, presence or absence of jaundice, presence or absence of a history of colic, presence or absence of gallstones, the degree of functional disturbance indicated by the cholecystogram, the pathologic stage of the disease (acute or chronic), and the type of operation have been studied with reference to the hospital mortality and the final symptomatic result. An additional factor studied has been the degree of pathologic change in the diseased gallbladder, an approach which has not previously been emphasized. The correlation between cholecystographic diagnosis and pathologic changes has also been studied.

The data have been subjected to statistical validation to define the significance of the results. The reason for such an attempt is obvious. Practical conclusions are commonly drawn from the percentage analysis of clinical material, based on samples so small or percentage differences so slight that the conclusions must be suspect. It has been deemed desirable not to add another such analysis without at least attempting to show whether the presented data have or have not statistical significance.

The method employed has been that involving the use of the "chi-square distribution."[2] This method furnishes an estimate of the significance of compared figures, taking into consideration the size of the samples from which they are derived. The mathematical end-point expressing such determinations of significance is a quantity designated *P*, which may be roughly described as indicating to what degree the element of pure chance has been influential in the results. Any data for which the calculated *P* is 0.01 or less may be considered significant. If *P* lies between 0.02 and 0.05, conclusions from data are probably significant. If greater than 0.05, the differences may be due to chance alone. The application of this method to the statistical studies here presented is indicated in the tables, in which both the value of *P* and the presence or absence of significance of the results are given. In the case of the statistical data referred to in the text alone and not presented in tabular form, the analysis revealed statistical validity in no instance.

The data are grouped under four heads: clinical, cholecystographic, pathologic and operative. They are presented without immediate reference to statistical evaluation, which is reserved for discussion later.

CLINICAL DATA

Age.—Judd and Priestley[3] demonstrated better results in the older patients undergoing cholecystectomy and cholecystostomy. The present study revealed an apparent tendency toward better ultimate results with increasing age from 21 to 60 years.

Sex.—In the entire series there were 517 females and ninety-three males, a ratio of 5.5 to 1. The results were satisfactory in 71.2 per cent of the males and 74.8 per cent of the females.

Race.—An approximately equal percentage of satisfactory results are observed in the white and Negro races (74.4 per cent in the former and 72.2 per cent in the latter). The operative mortality rate in the white race (540 cases) was 4.1 per cent, while in the Negro race there was no death in seventy cases.

Duration of Symptoms.—Study of the duration of symptoms of gallbladder disease before operation presents nothing conclusive. There is no apparent trend toward better ultimate results from operation with a history of symptoms of longer duration. An exceptionally high operative mortality (9.6 per cent) in the group of patients who had had symptoms from one week to one month before operation was noted.

Severity of Symptoms.—The final results in patients having had mild symptoms preoperatively are only slightly less satisfactory than in those in whom the symptoms had been severe. This unexpected finding can be explained only on the basis of the personal equation, here doubly operative first through the original recorder of the history and secondly through the collator of the material. There is an expected difference in operative mortality (4.5 per cent in the cases presenting severe symptoms as against 0.6 per cent in those presenting mild symptoms).

Jaundice and Colic.—Study of the ultimate results with relation to the presence or absence of definite jaundice and colic offers no positive conclusion. The percentage of satisfactory results in those cases without a definite history of colic is actually slightly higher than in those with a history of colic. These results are definitely contradictory to the usual observations recorded.[4] They also present the same discrepancy that was found in studying the severity of symptoms. Probably the same explanation must be given.

CHOLECYSTOGRAPHIC DATA

Numerous authors have compared the cholecystogram with the pathologic change found at operation. Brooks[5] concluded that "careful application of the method gives results on which the anatomical pathological change in the gallbladder may be estimated." Rose,[6] in a composite study of 6,268 cases reported by twenty authors, found that gallbladders diagnosed as abnormal by cholecystogram were pathologic in 93.3 per cent of cases. Case[7] stressed the point that cases of cholelithiasis examined by cholecystogram are almost certain to show either "no shadow" or "stone positive," or both, and found that both of these criteria were lacking in only 4.3 per cent of his cases. Ferguson and Palmer[8] found that cholecystographic diagnosis, when considered with clinical history, was pathologically correct in 90 per cent of cases.

In this series 252 cases were submitted to cholecystographic examination before operation. A comparison between the degree of functional disturbance as indicated by the x-rays and the symptomatic results reveals no marked differences in favor of the cases that presented marked x-ray evidence of gallbladder disease.

It might be noted in passing that, although the number of cases is small (fourteen), the ultimate results in cases of normal cholecystographic shadow are only 50 per cent satisfactory. This is of particular interest not only in the use of the normal cholecystogram as a warning against operation but also to point further the suggestion of Graham and Mackey[9] that a proportion of unsatisfactory results in gallbladder surgery arises from mistaken diagnosis.

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3. Judd, E. S., and Priestley, J. T.: Ultimate Results from Operations on the Biliary Tract, J. A. M. A. **99**: 887 (Sept. 10) 1932.
4. Palmer, W. L.: Gallbladder Disease: Remarks on Symptoms, Diagnosis and Treatment, Internat. Clin. **1**: 111 (March) 1935.
5. Brooks, Barney: Diagnosis and Treatment of Diseases of Gallbladder, South. M. J. **22**: 233 (March) 1929.
6. Rose, Cassie B.: Some Problems and Results in Cholecystography, Radiology **22**: 197 (Feb.) 1934.
7. Case, J. T.: Evaluation of Cholecystography, J. A. M. A. **92**: 291 (Jan. 26) 1929.
8. Ferguson, A. N., and Palmer, W. L.: Cholecystography: Its Clinical Evaluation, J. A. M. A. **100**: 809 (March 18) 1933.
9. Graham, E. A., and Mackey, W. A.: Consideration of Stoneless Gallbladder, J. A. M. A. **103**: 1497 (Nov. 17) 1934.

PATHOLOGIC DATA

Although it may be acknowledged that the estimate of the actual degree of pathologic change in the gallbladder wall is conditioned by a large personal equation, it is worth while to attempt to correlate the clinical results with this variable. After all, the duration of symptoms, the severity of symptoms, the presence or absence of colic and jaundice, and the changes in the cholecystographic shadow stem ultimately in most cases from anatomic alterations. This correlation has not often been emphasized. Weir and Snell [10] may be quoted as follows: "Permanent good results are obtained in from 80 to 95 per cent of cases in which stones are present, and in noncalculous disease of the gallbladder comparable results are obtained *when the pathologic process is advanced*" (italics ours).

TABLE 1.—*The Presence or Absence of Cholelithiasis and Results* *

	Cases	Hospital Mortality	Follow Up	Symptomatic Results: Satisfactory	Symptomatic Results: Unsatisfactory
Stone present...	423	15 3.5%	308	243 79.0%	65 21.0%
Stone absent....	187	7 3.7%	139	89 64.0%	50 36.0%
Total.....	610	22	447	332	115

* Statistical evaluation applied to operative mortality: P = 0.91; not significant. Statistical evaluation applied to symptomatic results: P = 0.01—; significant.

The degree of pathologic change in the gallbladder wall has been classified as "mild," "moderate" or "marked." No definite limits between these grades can be specified. The mild degree of change represents slight fibrosis and minimal infiltration with inflammatory cells, a pathologic picture not far removed from the normal. The moderate degree represents definite thickening of the gallbladder wall and unmistakable infiltration, often associated with pericholecystic adhesions and enlargement of the cystic lymph gland. All other cases including most of the cases of acute cholecystitis are placed in the third group.

Cholelithiasis Versus the Stoneless Gallbladder.—Cases with and without cholelithiasis, including both the acute and the chronic cases, have been compared as to results (table 1). It is noted that the mortality rate is equal in the two groups but that there is considerable difference in the percentage of satisfactory results obtained in favor of the group presenting stones. This finding agrees with accepted opinion.

A comparison was made in cases of chronic cholecystitis alone between those with and those without stone. In the cases with stone the hospital mortality was only 0.8 per cent (228 cases) as contrasted with a mortality rate of 3.3 per cent (151 cases) in those without stone. These figures do not include cases presenting chronic cholecystitis and stone in the common duct, of which there were twenty-eight, with an operative mortality of 10.7 per cent. The significance of the difference between the first two mortality rates is not clear. It is possible that the cases of chronic cholecystitis without stone may represent those cases in which the diagnosis was wrong. The stoneless case is obviously less accurately diagnosed. The symptoms for which operation was done in certain of the stoneless cases may have originated from coronary disease or some other condition unrelated to the disease of the gallbladder.[9]

Degree of Pathologic Change.—The comparison of symptomatic results as related to the degree of pathologic change and as related to the presence or absence of stone presents interesting data (table 2). In the stoneless group, the group with stone, and the combined group, the results are about 80 per cent satisfactory when a marked degree of pathologic change is found. It is suggested by these figures and by those presented in table 1 that about 80 per cent of satisfactory symptomatic results may be expected when either cholelithiasis or a marked degree of pathologic change is present.

Comparison between the radiographic measurement of gallbladder function and the degree of pathologic change reveals a close correlation when the total 252 cases submitted to cholecystography are considered (table 3 *C*). As might be predicted, this correlation is also close in the cases complicated by stone (table 3 *A*). On the other hand, in the stoneless group, although some tendency toward the same correlation is apparent (table 3 *B*), it is not so close. These results agree with the generally accepted conclusions in regard to the value of the cholecystogram used as an index of functional integrity of the gallbladder.

TABLE 2.—*Degree of Pathologic Change and Results*

Degree of Pathologic Change	Cases	Hospital Mortality	Follow Up	Symptomatic Results: Satisfactory	Symptomatic Results: Unsatisfactory
A. With Stone*					
Mild.....	20	0	20	12 60.0%	8 40.0%
Moderate.....	278	6 2.1%	190	150 79.0%	40 21.0%
Marked.....	125	9 7.2%	98	81 82.7%	17 17.3%
Total.....	423	15	308	243	65
B. Without Stone†					
Mild.....	85	5 5.8%	66	37 56.0%	29 44.0%
Moderate.....	80	2 2.5%	58	40 69.0%	18 31.0%
Marked.....	22	0	15	12 80.0%	3 20.0%
Total.....	187	7	139	89	50
C. With and Without Stone‡					
Mild.....	104	5 4.8%	86	49 57.0%	37 43.0%
Moderate.....	359	8 2.2%	248	190 76.6%	58 23.4%
Marked.....	147	9 6.1%	113	93 82.2%	20 17.8%
Total.....	610	22	447	332	115

* Statistical evaluation applied to operative mortality: P = 0.029; probably significant. Statistical evaluation applied to symptomatic results: P = 0.09; not significant.

† Statistical evaluation applied to operative mortality: P = 0.34; not significant. Statistical evaluation applied to symptomatic results: P = 0.12; not significant.

‡ Statistical evaluation applied to operative mortality: P = 0.17; not significant. Statistical evaluation applied to symptomatic results: P = 0.01—; significant.

Acute Versus Chronic.—We have compared the results following operation in cases presenting pathologically acute gallbladders with the results in those cases which were not acute. It is apparent that there

10. Weir, J. F., and Snell, A. M.: Symptoms That Persist After Cholecystectomy, J. A. M. A. **105**: 1093 (Oct. 5) 1935.

is often some lack of clarity in the use of the word "acute." The pathologically acute gallbladder is not always the clinically acute gallbladder. Not infrequently after the subsidence of fever, leukocytosis, increased pulse rate, pain and tenderness, operation will reveal a gallbladder the condition of which is pathologically that of acute inflammation. If a decision is to be reached on the desirability of early surgery in acute cholecystitis, observers must come to some uniformity in the definition of acute cholecystitis. It must be specified as to whether the term is used to describe the clinical course or the pathologic picture. In the present instance we have confined the use of the word to the latter. The group of cases, therefore, classified as acute contains a proportion of cases in which acute symptoms have largely subsided. It must be remembered in this connection that what appears to be pus in the gallbladder has been said to be not necessarily a purulent exudate.[11]

TABLE 3.—*Cholecystogram and Pathologic Change*

Degree of Pathologic Change	Normal Shadow	Good Shadow	Poor Shadow	No Shadow	
A. With Stone*					
Mild	3	4	0	1	
Moderate	2	7	25	76	
Marked	0	0	10	30	
Total	5	11	35	107	158
B. Without Stone†					
Mild	11	12	17	11	
Moderate	4	5	13	17	
Marked	0	0	2	2	
Total	15	17	32	30	94
C. With and Without Stone‡					
Mild	14	16	17	12	
Moderate	6	12	38	93	
Marked	0	0	12	32	
Total	20	28	67	137	252

* P = 0.01—; significant.
† P = 0.296; not significant.
‡ P = 0.01—; significant.

This comparison between the acute cases, on the one hand, and the subacute and chronic, on the other hand, shows very slightly better results in the former group.

OPERATIVE DATA

Choice of Time for Operation in Acute Cases.—During the past twelve years there has been a gradual change of opinion with regard to the treatment of acute cholecystitis. Moynihan,[12] Lewis,[13] McGuire,[14] Deaver and Burden,[15] and Bruggeman [16] have earlier expressed themselves as in favor of nonoperative treatment of cholecystitis during the clinically acute stage, an exception being made when the patient under observation becomes definitely worse. As early as 1923, however, Walton [17] compared acute cholecystitis to acute appendicitis and advised immediate operation. This opinion was supported by the observation of Crile [18] showing a larger percentage of cures following cholecystectomy in the acute stage than in the chronic stage. Later Mentzer,[19] Zinninger,[20] Graham,[21] Miller,[22] and Stone and Owings [23] expressed the opinion that early operative treatment is preferable to expectant treatment. Judd and Phillips,[24] as a result of a study of 508 cases of acute cholecystitis, concluded that early operation seems to be justified. Miller [22] found that the average length of time from the onset of acute symptoms to operation in fatal cases of acute cholecystitis was 15 days, and in those in which recovery occurred, 8.3 days.

In the present series the average interval between the onset of acute symptoms and operation was 11.1 days in fatal cases and 8.1 days in those in which recovery occurred. The operative mortality for the acute group was 4.7 per cent (seven cases). One patient died of peritonitis, three of pneumonia, one of empyema of the pleura, one of multiple liver abscesses and one of "circulatory collapse." Six instances of rupture of the gallbladder were found in 610 cases, operation being performed in one instance on the day of onset of acute symptoms. Other cases of rupture were discovered at operation two, four, six, seven and eleven days after the onset. One patient with a ruptured gallbladder found at operation two days after onset of symptoms died of peritonitis.

TABLE 4.—*Acute Cholecystitis: Time of Operation and Mortality*

Time of Operation After Onset	Cases	Lived	Died
A. Our Studies*			
Within 48 hours	11	11 100.0%	0
After 48 hours	138	131 95.0%	7 5.0%
Total	149	142	7
B. Graham's [21] Studies†			
Within 48 hours	20	19 95.0%	1 5.0%
After 48 hours	178	167 93.8%	11 6.2%
Total	198	186	12
C. Zinninger's [20] Studies‡			
Within 48 hours	12	12 100.0%	0
After 48 hours	23	20 86.9%	3 13.1%
Total	35	32	3
D. Total Studies (A, B and C)§			
Within 48 hours	43	42 97.7%	1 2.3%
After 48 hours	339	318 93.8%	21 6.2%
Total	382	360	22

* Statistical evaluation: P = 0.42; not significant.
† Statistical evaluation: P = 0.54; not significant.
‡ Statistical evaluation: P = 0.19; not significant.
§ Statistical evaluation: P = 0.29; not significant.

In the group of cases pathologically acute, we have studied the mortality rate and the ultimate clinical

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12. Moynihan, Berkley: Personal communication to Bruggeman.[16]
13. Lewis, Dean: Personal communication to Bruggeman.[16]
14. McGuire, Stuart: Gallbladder Surgery, Virginia M. Monthly **50**: 688 (Jan.) 1924.
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16. Bruggeman, H. O.: Treatment of Acute Cholecystitis, Ann. Surg. **87**: 423 (March) 1928.
17. Walton, A. J.: A Textbook of the Surgical Dyspepsias, London, E. Arnold, 1923, p. 512.
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22. Miller, R. H.: Acute Cholecystitis, Ann. Surg. **92**: 644 (Oct.) 1930.
23. Stone, H. B., and Owings, J. C.: Acute Gallbladder as Surgical Emergency, Ann. Surg. **98**: 760. (Oct.) 1933.
24. Judd, E. S., and Phillips, J. R.: Acute Cholecystic Disease, Ann. Surg. **98**: 771 (Oct. 7) 1933.

result with relation to the degree of clinical acuteness as measured by the time of operation following the onset of symptoms. If grouped by two-day intervals the number of cases in each group is too small to have significance and no regular variation in mortality is found with an increasing interval between onset of symptoms and operation.

If, however, we group the cases under the formula used by both Zinninger [20] and Graham,[21] dividing the acute cases at the forty-eight hour period, the operative mortality is found to be zero in eleven cases in which operation was done within forty-eight hours after onset of symptoms as compared to an operative mortality of 5 per cent in 138 cases in which operation was done later (table 4 *A*). This difference will be discussed later.

Type of Operation.—For the sake of completeness, the types of operation were compared in regard to the results. The best ultimate results were apparently obtained from combined cholecystectomy and choledochostomy. With the exception of three cases of choledochostomy alone, however, this group also carried the highest operative mortality (12.3 per cent of seventy-three cases). It is of interest to note that, of those patients who underwent choledochostomy with or without cholecystectomy, 8.7 per cent were reported by relatives as dead with a recurrence of symptoms, while of those undergoing simple cholecystectomy only 1.3 per cent of 518 patients had died with any recurrence of symptoms.

COMMENT

Since no statistically valid figures dealing with results are omitted from the accompanying tables, it will be seen that few of the data presented withstand the scrutiny of statistical evaluation. In spite of a fairly large number of cases, the great majority of comparisons recorded have no statistical significance. The application of this method with the same result to a number of tables published by other authors has cast doubt in our minds on much that has been accepted as proved on the basis of measured clinical results. Perhaps the value of the present contribution lies not only in the results themselves but also in pointing out what havoc may be wrought with percentage conclusions from clinical material when statistical validation of the data is attempted.

The only comparisons that statistical control shows to be significant between the criteria studied and the symptomatic results obtained are those dealing first with gallstones and secondly with the degree of pathologic change in the gallbladder wall. When gallstones are present, clinical results are 79 per cent satisfactory as compared to 64 per cent satisfactory when they are absent (table 1). When the pathologic change in the gallbladder wall is marked, the clinical results are 82.2 per cent satisfactory; when it is moderate, 76.6 per cent satisfactory, and when it is mild, only 57 per cent satisfactory (table 2 *C*). These two results give weight to the conclusion rather generally expressed in present-day thought that the patient with a really diseased gallbladder has an excellent chance of a satisfactory symptomatic result if the gallbladder is removed.[25] The problem resolves itself into one of accurate diagnosis.

In this connection it is interesting that the correlation between the degree of pathologic change and the degree of deviation of the cholecystogram from the normal is statistically significant (table 3 *C*). This finding offers support to the general attitude of reliance on the cholecystogram as a diagnostic aid.

One of the correlations dealing with hospital mortality, although shown to have no statistical significance, deserves discussion. It has already been noted that in eleven cases of pathologically acute cholecystitis, in which operation was done within forty-eight hours after onset of symptoms, the mortality was 0 per cent, whereas in 138 patients operated on later the mortality was 5 per cent (table 4 *A*). An obvious temptation is presented to draw conclusions that are shown by statistical evaluation to be not justified. In an attempt by increasing the size of the sample to bring corresponding comparisons within the realm of significance, we have subjected the combined figures of Graham,[21] Zinninger [20] and our own to statistical inquiry (table 4). It is seen in this table that no one of the three series taken separately has statistical significance; nor has the summation of the three series, in spite of the fact that the mortality of cases in which operation was done more than forty-eight hours after onset of symptoms is almost three times that of cases in which operation was done earlier. In other words, it can be said that the desirability of early operation in acute cholecystitis has not been proved by these figures which base judgment on mortality rates.

SUMMARY

1. Analyses of a series of 610 consecutive cases of cholelithiasis and cholecystitis covering a period of thirteen years gives a hospital mortality rate of 3.6 per cent. The follow up of survivors includes 447 cases (76 per cent).

2. In addition to the usual percentage tabulation, the data are statistically controlled by the method of "chi-square distribution."

3. This method demonstrates in the present series no statistical significance in comparisons between the symptomatic results and such factors as age, sex, race, duration of symptoms, severity of symptoms, presence or absence of jaundice, presence or absence of a history of colic, the degree of functional disturbance indicated by the cholecystogram, the pathologic stage of the disease (acute or chronic) and the type of operation.

4. Following the application of statistical analysis to the data, these conclusions are justified:

(*a*) Cases of cholelithiasis present satisfactory clinical results in 79 per cent of cases; cases without stone, in 64 per cent.

(*b*) Cases that show a marked degree of pathologic alteration of the gallbladder wall present satisfactory clinical results in 82.2 per cent of cases; with a moderate degree of alteration, 76.6 per cent; with a mild degree, 57 per cent.

(*c*) The cholecystogram is a significant index of the degree of pathologic change in the gallbladder.

(*d*) The desirability of early operation in acute cholecystitis is not proved when measured by mortality rates.

25. Andrews, Edmund: Must We Revise Our Indications for Cholecystectomy? Internat. Clin. **3**: 172 (Sept.) 1935.

The Calcium Requirement.—The amount of calcium needed in the normal maintenance nutrition of the human adult has been carefully investigated by means of large numbers of calcium-balance experiments made with healthy men and women. In the average of about 100 such experiments, it has been found that the body requires for mere maintenance, that is, in order that it shall not persistently lose calcium from its own tissues, 0.45 gram of calcium per day per 154 pounds of body weight. —Sherman, H. C.: Food and Health, New York, Macmillan Company, 1934.

A STUDY OF DIABETES MELLITUS AMONG EX-SERVICE MEN

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A study of diabetes mellitus similar to the present one was made in 1931 and included a clinical, laboratory and dietetic survey of a group of 300 diabetic veterans for the purpose of ascertaining whether the conditions found in the veteran population were comparable with those seen in civil life. The study showed that 13 per cent of the group first gave evidence of the diabetic disease during the period of military service at an average age of 32 years and that 87 per cent gave a history of the onset of the disease after discharge from the military service, at an average age of 37 years.

In the study referred to an effort was made to learn whether or not the traumas of warfare and certain neurogenic factors observed in the military service were in any way related to the inception of the diabetic condition. In addition, an inquiry was made to ascertain whether or not postwar social and economic hardships and maladaptations were in any way conducive to the diabetic state. The evidence in favor of the conditions enumerated as etiologic factors were not convincing. The inception of the disease could be better explained on the basis of constitutional predisposition, obesity, faulty metabolism, concomitant internal secretory disturbances and certain other individual factors.

CLASSIFICATION

The present study includes 1,663 living diabetic veterans. These patients were grouped according to the classification of the diabetic condition as suggested by Joslin. The diagnostic data in each case were carefully reviewed and the patient was placed in a particular group only after he had met all the criteria required for that particular classification.

Table 1 shows that, of the total number of diabetic veterans, true diabetes mellitus was found in 88.6 per cent, potential diabetes in 8.9 per cent, unclassified diabetes mellitus in 1.7 per cent and renal glycosuria in 0.8 per cent.

In comparing these data with similar data of Joslin,[1] it is noted that the incidence of potential diabetes mellitus in Joslin's group is very much smaller than in the present study. The explanation is that the veterans are a younger group of men of an average age of 43 years. It is probable that many of the cases of potential diabetes mellitus will eventually be reclassified and found to be cases of true diabetes mellitus.

It is of interest to note that twenty-eight, or 1.7 per cent, of the group were found to have unclassified diabetes mellitus. This compares with 10 per cent of Joslin's group of 13,000 cases. It is possible that, as the veterans grow older and are subject to various diseases commonly associated with this type of diabetes, the incidence of unclassified diabetes mellitus will increase. In addition it was found that sixty-one cases of the total group gave evidence of some coexisting abnormality of one or more of the internal secretory glands; however, it was decided that, in spite of this fact, the diabetic condition met the criteria established for true diabetes mellitus.

It is noted that the incidence of renal glycosuria in the present study is 0.8 per cent, as compared with 0.3 per cent in Joslin's group. Although the criteria of Joslin were applied in the present instance, it is nevertheless possible that, on further observation and study, certain of the patients will eventually be found to present evidence of potential or true diabetes mellitus.

HEREDITARY AND FAMILIAL HISTORY

Baur, Fischer and Lenz [2] state that a simple dominant heredity is not the rule in diabetes mellitus. These observers hold that the reason for the difficulty in tracing the inheritance of diabetes mellitus through several generations is the inability or difficulty to recognize the disease, and also that many persons with potential diabetes die from other causes before true diabetes mellitus becomes manifest. It is the opinion of Baur, Fischer and Lenz that in most cases diabetes mellitus is the result of a recessive hereditary factor. Furthermore, the disease may skip one or more generations, and the genealogies in the literature generally support this view. Joslin [3] found that the disease goes down through the males rather than the females. The reason given is that every other pregnancy in a diabetic woman

TABLE 1.—*Classification of Group of 1,663 Diabetic Veterans*

	Number	Per Cent
True diabetes mellitus	1,473	88.6
Potential diabetes mellitus	149	8.9
Unclassified diabetes mellitus	28	1.7
Renal glycosuria	13	0.8
Totals	1,663	100.0

results in a stillborn infant. Pincus and White [4] hold that the incidence of diabetes is higher in families of diabetic patients than in families of nondiabetic persons.

Priscilla White [5] is of the opinion that diabetes mellitus is transmitted as a simple mendelian recessive. Pincus and White [6] hold that diabetes mellitus, because of the fact that it is frequently not immediately identifiable and is manifested in different individuals at different ages, is not as easily proved to be an inherited disease, although they found ratios consistent with simple mendelian recessiveness.[1]

White, Joslin and Pincus [7] found that the difference between the occurrence of diabetes in a diabetic and a control population was that 2 per cent of the parents of the control population had diabetes mellitus whereas 8 per cent of the parents of the diabetic patients had the disease. Diabetes occurred ten times more frequently in brothers and sisters of diabetic patients than in the control group.

In this connection it is important to bear in mind the fact that other factors than heredity play a part in the inception of the disease. Some of these factors are abnormal endocrine activity, obesity and infections.

From the Medical and Hospital Service, Veterans' Administration.
Dr. Elliott P. Joslin of Boston and Dr. Louis I. Dublin of New York offered valuable suggestions in this work. Cooperation was given by the medical officers of the various Veterans' Administration Facilities. A. Bambery, assistant statistician, and O. M. Allen of the Research Subdivision, Medical and Hospital Service, assisted in the statistical work of this study.

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In a previous study I [8] found that 10.6 per cent of a group of 300 diabetic veterans gave evidence of a hereditary or familial history of the disease. Of this group of 1,663 veterans 145, or 8.7 per cent, gave a hereditary, familial or combined hereditary and familial history of diabetes mellitus. Of this number seventy-two gave a hereditary history, fifty-four gave a familial history and nineteen gave a combined familial and hereditary history of the disease.

Of the seventy-two veterans with a hereditary history, sixty-four gave evidence of true diabetes mellitus and eight of potential diabetes mellitus. The largest groups, thirty-one and thirty-three, showed the presence of the disease in the father and mother respectively.

Of the fifty-four veterans with a familial history of the disease, fifty were patients with true diabetes mellitus, two had potential diabetes mellitus, one had unclassified diabetes mellitus, and one had renal glycosuria. The largest groups, eighteen and thirty-three, showed the presence of the disease in the sister and brother respectively.

Of the nineteen veterans with a combined hereditary and familial history, seventeen had true diabetes mellitus and two had potential diabetes mellitus. The largest groups, four, three and two, showed the presence of the disease in father and brother, mother and brother, and mother and sister respectively.

AGE AT ONSET

In a previous study I [8] found that 25.3 per cent of a group of diabetic veterans gave evidence of the onset of the disease within the age group 30-35, 19 per cent within the age group 35-40 and 18 per cent within the age group 25-30. Seventy and nine-tenths per cent of the group gave evidence of the diabetic condition prior to age 40, while 29.1 per cent showed the presence of the disease after that age. In this connection it is desired to point out that the largest number of these diabetic veterans were World War veterans whose average age at the time of diagnosis was 33.7 years.

Pincus, Joslin and White [9] state that a true picture of the susceptibility to diabetes at various ages is given by the ratio of the number of persons developing the disease to the number exposed to the disease in those ages. In their study of the rate of onset of diabetes by age groups, these observers found that the maximum susceptibility to the development of the diabetic disease occurred in the sixth decade. More detailed figures showed that age 51 among males was the age of maximum susceptibility. The onset rates further indicated that there is a declining susceptibility to diabetes in the later decades.

Joslin [1] states that, in the past, discussions and statistics on the incidence of diabetes were wrong, because they were based on the dead instead of on the living. This observer in a study of the age at onset of 4,639 diabetic patients, treated between 1898 and 1933 found that the maximum susceptibility to the development of the disease in males occurred in the sixth decade; 24.19 per cent of the males gave evidence of the onset of the disease in this decade. The susceptibility to the development of diabetes rose steadily to this maximum and thereafter declined.

According to Joslin the most significant aspect of the onset rates is the declining susceptibility to diabetes in the later decades, thus indicating that the disease is not characteristic of old age and is therefore not a manifestation of senility. It is his opinion that the onset of diabetes depends on a complex of events of endocrine origin which attain fruition between the ages of 40 and 60 years.

In a study of the age at onset of diabetes, Joslin showed that the acme of the onset of the disease comes in the five year period 50 to 54 years, during which period 14.4 per cent of the males give evidence of the disease. The onset rate was 10.3 per cent in the 40 to 44 year period, 12.7 per cent in the 45 to 49 year period and 10.7 per cent in the 55 to 59 year period. The median age at onset for all the males was 46.5 years.

TABLE 2.—*Classification of 145 Cases of Diabetes Mellitus with a Hereditary, a Familial or a Combined Hereditary and Familial History of the Disease by Type of Diabetes Mellitus and Member of Family Affected*

		Diabetes Mellitus			
	Total	True	Potential	Unclassified	Renal Glycosuria
Hereditary history:					
Father	31	28	3	..	..
Mother	33	28	5	..	..
Aunt	1	1	..	..	..
Uncle	1	1	..	..	..
Father and mother	2	2	..	..	..
Grandfather	3	3	..	..	..
Father and uncle	1	1	..	..	..
Total cases giving a hereditary history	72	64	8	0	0
Familial history:					
Sister	18	17	1	..	..
Brother	33	30	1	1	1
Cousin	1	1	..	..	..
3 brothers and 1 sister	1	1	..	..	..
Brother and sister	1	1	..	..	..
Total cases giving a familial history	54	50	2	1	1
Hereditary and familial history:					
Mother and brother	3	3	..	..	..
Mother and sister	2	2	..	..	..
Mother, brother and sister	1	1	..	..	..
Mother, 2 brothers and sister	1	1	..	..	..
Mother, father and brother	1	1	..	..	..
Father and brother	4	4	..	..	..
Father and sister	1	1	..	..	..
Mother, father and sister	1	1	..	..	..
Father, brother, uncle, aunt and cousin	1	..	1	..	..
Grandfather, aunt and cousin	1	1	..	..	..
Brother, uncle and 2 cousins	1	1	..	..	..
Uncle and sister	1	1	..	..	..
Uncle and cousin	1	..	1	..	..
Total cases giving a hereditary and familial history	19	17	2	0	0
Grand totals	145	131	12	1	1

In this connection it might be stated that there is a difference between the onset rate of diabetes mellitus and the mortality rate of the disease. The onset rates indicate that after the age of 60 is reached the chance of developing diabetes mellitus decreases, while the mortality rates indicate that the older one grows the greater are the chances of dying from diabetes.

According to Joslin, the statistics point to two cardinal ideas: that (1) emphasis should be placed on the prevention of the onset of diabetes in middle life and (2) the chief concern in the treatment of the disease should be with its late complications, because at present few diabetic patients die when young or of diabetes per se.

Table 3 gives a classification of 1,663 diabetic veterans according to the type of the disease as well as the age at the time of onset of the diabetic condition.

8. Matz, P. B.: A Study of Diabetes Mellitus Among Ex-Service Men, Mil. Surgeon **68**: 591 (May) 1931.

9. Pincus, Gregory; Joslin, E. P., and White, Priscilla: The Age Incidence Relations in Diabetes Mellitus, Am. J. M. Sc. **188**: 6-122 (July) 1934.

In this connection it is important to remember that the average age of the entire veterans group (approximately 4,409,247) was 44 years at the time of this study, and, furthermore, 93 per cent of this number, or approximately 4,193,373, were World War veterans of an average age of 43 years.

A study of the data in table 3 indicates that the largest number, 850, or 51 per cent of the group of 1,663 diabetic veterans, gave evidence of the onset of the disease within the age group 30 to 39. It is further noted that 80 per cent gave evidence of the disease before the age of 40 and 20 per cent after the age of 40. The average age of the group of 1,663 veterans at the time of the onset of the diabetic condition was 33.7 years.

The data in table 3 are not in accord with the data of Joslin; the latter found that the acme of the onset of the disease comes in the five year period 50 to 54 years. In the ex-service group the acme of the onset of the disease appeared to be within the age group 30 to 34. The reason for the difference appears to be that we are dealing with a select group of young males, whose average age is approximately 44 years.

TABLE 3.—*Age at Time of Onset*

	Total		True Diabetes Mellitus		Potential Diabetes Mellitus		Unclassified Diabetes Mellitus		Renal Glycosuria	
Age, Years	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Up to 14	1	0.1	1	0.1	..	....	..	....	..	....
15-19	16	1.0	13	0.9	..	....	1	3.6	2	15.4
20-24	162	9.7	149	10.1	7	4.7	3	10.6	3	23.0
25-29	297	17.9	275	18.7	17	11.4	4	14.3	1	7.7
30-34	430	25.8	385	26.1	36	24.1	7	25.0	2	15.4
35-39	420	25.2	356	24.1	53	35.6	7	25.0	4	30.8
40-44	240	14.4	212	14.4	24	16.1	4	14.3	..	....
45-49	58	3.5	50	3.4	7	4.7	1	3.6	..	....
50-54	21	1.3	17	1.1	3	2.0	..	....	1	7.7
55-59	10	0.6	9	0.6	1	0.7	..	....	..	....
60-64	5	0.3	4	0.3	1	0.7	..	....	..	....
65-69	2	0.1	1	0.1	..	....	1	3.6	..	....
70-74	1	0.1	1	0.1	..	....	..	....	..	....
Totals	1,663	100.0	1,473	100.0	149	100.0	28	100.0	13	100.0
Av. age	33.7		33.5		35.4		35.8		30.5	

These data indicate that true diabetes mellitus as well as the other diabetic conditions may develop in the younger age groups and at a greater rate than is commonly supposed. It is safe to state that diabetes mellitus is a disease of youth as well as middle age. Furthermore, if the diabetic condition continues to appear in the higher age groups and at a higher rate of onset we may expect to see a larger number of diabetic veterans in the years to come, thus increasing the problem of the treatment of diabetic ex-service men in the Veterans' Administration.

DURATION OF LIFE

The prognosis and the duration of life in diabetes mellitus depend on a number of factors: first, the type of the disease, whether it is mild or severe; second, whether or not insulin is being administered; third, on the general physical condition of the patient aside from the diabetes; fourth, on whether or not complications or coexisting diseases are present; and, lastly, on whether or not the diabetic patient cooperates fully with his physician and undergoes the regimen according to the requirements in his case.

Joslin [1] states that in the Naunyn era (before 1914) the average duration of life subsequent to the onset of diabetes was 4.8 years. In the Allen period (1914-1922) the average duration had increased to six years. In the early Banting period (1922-1925) the average duration was 7.6 years. In the middle Banting period (1926-1929) it had increased to 8.4 years. In the later Banting period from Jan. 1, 1930, to the present, the average duration had increased to eleven years.

Of the 1,252 living diabetic veterans who are being treated with insulin, 1,243 have a diagnosis of true diabetes mellitus and nine unclassified diabetes mellitus. Of this group 318, or 25.4 per cent, have survived the disease from six months to five years; 394, or 31.5 per cent, from five to ten years; 279, or 22.3 per cent, from ten to fifteen years, and 261, or 20.8 per cent, from fifteen to over eighteen years. Accordingly 43.1 per cent of the group of diabetic patients treated with insulin have survived the disease ten years or longer.

The longest duration of the group of 1,243 cases of true diabetes mellitus was forty-two years, the shortest eight months, and the average duration to the date of this study 9.1 years.

Of the nine living patients with unclassified diabetes mellitus the longest duration was sixteen years, the shortest duration was 3.6 years, and the average duration to the date of this study was 12.8 years.

Four hundred and eleven of the living diabetic patients are not receiving insulin as a routine treatment, 230 have true diabetes mellitus, 149 potential diabetes mellitus, nineteen unclassified diabetes mellitus and thirteen renal glycosuria.

Of the 411 diabetic or renal glycosuric patients 188, or 45.7 per cent, have lived from less than six months to five years; 119, or 29 per cent, have lived from five to ten years; forty-four, or 10.7 per cent, have lived from ten to fifteen years, and sixty, or 14.6 per cent, have lived from fifteen to over seventeen years. It is thus seen that 25.3 per cent of the group of diabetic patients not treated with insulin have survived the disease ten years or longer.

Of the 230 patients with true diabetes mellitus who were not treated by insulin, the longest duration up to the date of this study has been twenty-eight years, the shortest eleven months, and the average duration 7.2 years.

In the group of 149 patients classified as having potential diabetes mellitus the longest duration has been 16.7 years, the shortest duration four months and the average duration 6.7 years.

Among the nineteen patients with a diagnosis of unclassified diabetes mellitus the longest duration has been fifteen years, the shortest duration 1.5 years and the average duration 7.4 years.

Of the thirteen with renal glycosuria the longest duration has been twenty-one years, the shortest duration 3.8 years and the average duration 12.5 years.

INSULIN

In the management of true and unclassified diabetes mellitus it is essential that the treatment be individualized. If possible the patient should first be treated by a diet and an effort should be made to have the urine sugar free and the blood sugar reduced to a normal percentage. If an endocrine abnormality or gallbladder disease is a factor in the causation of the diabetic condition, an effort should be made to overcome or remove the cause. If, after a serious effort is made to reduce the hyperglycemia and to remove the sugar from the urine by diet and other measures, the desired results are not attained, steps should be taken to ascertain the number of units of insulin required to overcome the

diabetic condition and the patient should be placed on a combined dietetic and insulin regimen.

Joslin [1] states that diabetes is never complete. This complicates the problem of the therapeutics with insulin, because one never knows how much insulin the active pancreatic remnant yields and therefore how much insulin must be supplied to the diabetic patient.

In a previous study I [8] found that 240, or 80 per cent, of a group of 300 diabetic patients had received insulin during the course of treatment. Table 4 indicates that of 1,473 cases of true diabetes mellitus 1,243, or 84.4 per cent, had been treated by insulin and 230, or 15.6 per cent, had not received insulin. Furthermore, of twenty-eight patients with unclassified diabetes mellitus nine, or 32.1 per cent, had been treated by insulin and nineteen, or 67.9 per cent, had not received insulin.

TABLE 4.—*Number of Patients Receiving Insulin; Also Number Treated Without Insulin*

	Total	Number of Patients Receiving Insulin		Number of Patients Not Receiving Insulin	
		Number	Per Cent	Number	Per Cent
True diabetes mellitus	1,473	1,243	84.4	230	15.6
Potential diabetes mellitus	149	.....	....	149	100.0
Unclassified diabetes mellitus	28	9	32.1	19	67.9
Renal glycosuria	13	.....	....	13	100.0
Total cases	1,663				

In considering the question of whether a diabetic patient should or should not receive insulin the physician is confronted with a number of problems. In the first place it is important to know whether the disease is mild or severe, whether a dietetic regimen alone will control the hyperglycemia and glycosuria, and lastly whether the case is one of true or unclassified diabetes; if the latter, an effort should be made to eliminate or overcome the particular condition that may be the cause of the reduced carbohydrate tolerance.

It is believed that good medical practice dictates that insulin should not be administered until after other means such as diet, the correction of abnormal endocrine disturbance and the reduction of weight are first resorted to. When these measures fail, the physician may administer insulin to compensate for the reduced pancreatic activity.

RESULT OF TREATMENT

The result of the treatment of diabetes depends on the type of diabetic disease and its severity; also on the professional ability and judgment of the physician and the intelligence and cooperation of the diabetic patient. The physician who treats diabetes mellitus should be familiar with the nature of the various types of diabetic conditions, with the complications of true diabetes mellitus and with their proper management.

Numerous dietetic and therapeutic regimens have been recommended for the treatment of the disease. The adherents and proponents of each regimen are able to show good results with the particular treatment used. Accordingly, it is difficult for an impartial observer to decide which of the several regimens is the best for the patient.

It would appear that the ideal form of treatment is one that individualizes the diabetic patient and in which an effort is made to diminish the existing physiologic burden by reducing the intake of the protein, fat and carbohydrate foodstuffs until the urine becomes sugar free and the blood sugar is within normal range. If glycosuria and hyperglycemia cannot be eliminated by a modification of the diet, it becomes necessary to administer insulin for that purpose as well as to assist the patient with the assimilation and oxidation of the requisite amount of foodstuffs to yield sufficient energy and maintain body weight.

It is essential for the physician who treats diabetes mellitus to teach the patient all he should know about the disease and its management. In other words, the treatment of the diabetic patient should include instruction in the fundamental concepts of the disease and its management.

As the diabetic patient dies usually from complications of the disease, it should be the aim of the physician to prevent complications, and if perchance any should appear, the patient should receive immediate appropriate treatment. Another objective of the treatment is to increase the patient's tolerance for carbohydrates.

In a previous study [8] in which an effort was made to ascertain the result of the treatment of a small group of cases of true diabetes mellitus without insulin, it was found that of a total of forty-four cases eighteen, or 40 per cent, of the number gave evidence of satisfactory control of the diabetic condition; in nineteen, or 43 per cent, the diabetic condition was partially controlled; five, or 11 per cent, were uncontrolled, and two patients, or 5 per cent, died following treatment.

In the study it was also ascertained that of 237 cases of true diabetes mellitus treated by insulin forty, or 17 per cent of the group, gave evidence of satisfactory control of the diabetic condition; in 156, or 66 per cent, the diabetic condition was partially controlled; twenty-nine, or 12 per cent, were uncontrolled; and twelve patients, or 5 per cent, died following treatment.

Table 5 indicates that of 230 cases of true diabetes mellitus that were not treated by insulin 146, or 63.6 per cent, gave evidence of satisfactory control; fifty-nine, or 25.7 per cent, were partially controlled, and twenty-five, or 10.7 per cent, were uncontrolled. Of 149 cases of potential diabetes mellitus 123, or 82.6 per cent, were controlled, and twenty-six, or 17.4 per cent, were partially controlled. Of nineteen cases of unclassified diabetes mellitus the diabetic condition was controlled in sixteen, or 84.2 per cent, and the condition was partially controlled in three, or 15.8 per cent. Of thirteen cases of renal glycosuria twelve, or 92.3 per cent, were controlled and one, or 7.7 per cent, was partially controlled. Taking the whole group of 411 cases not treated by insulin, 297, or 72.3 per cent, were controlled; eighty-nine, or 21.6 per cent, were partially controlled, and twenty-five, or 6.1 per cent, were uncontrolled.

TABLE 5.—*Result of Treatment of 411 Diabetic Cases Without Insulin, by Clinical Classification of the Diabetic Condition*

	Total Cases	Controlled		Partially Controlled		Uncontrolled	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
True diabetes mellitus	230	146	63.6	59	25.7	25	10.7
Potential diabetes mellitus	149	123	82.6	26	17.4	..	....
Unclassified diabetes mellitus	19	16	84.2	3	15.8	..	....
Renal glycosuria	13	12	92.3	1	7.7	..	....
Totals	411		72.3		21.6		6.1

Table 6 indicates that of the group of 1,243 cases of true diabetes mellitus treated by insulin the diabetic condition was controlled in 382, or 30.7 per cent, the condition was partially controlled in 582, or 46.8 per cent, and the condition was not controlled in 279, or 22.5 per cent.

Of the nine cases of unclassified diabetes mellitus six, or 66.7 per cent, were controlled; two, or 22.2 per cent, were partially controlled, and one, or 11.1 per cent, was uncontrolled.

A careful study of the data in tables 5 and 6 indicates that insulin was used to a larger extent in the treatment of true and unclassified diabetes mellitus than were dietetic and other regimens. It was also noted that a much larger percentage of the cases of true diabetes mellitus had the disease controlled by diet alone than by the use of insulin. The reason is that the cases treated by diet were of a milder type than those treated by insulin. This is further supported by the fact that larger percentages of insulin-treated cases showed partial control, and complete uncontrol of the diabetic condition. It means that the condition of the diabetic patients treated with insulin was at times such as not to respond favorably to this therapeutic agent. The data further indicate that unclassified diabetes mellitus treated by insulin showed better results than cases of true diabetes mellitus similarly treated.

TABLE 6.—*Result of Treatment of 1,243 Diabetic Cases with Insulin by Clinical Classification of the Diabetic Condition*

	Total Cases	Controlled		Partially Controlled		Uncontrolled	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
True diabetes mellitus	1,243	382	30.7	582	46.8	279	22.5
Unclassified diabetes mellitus	9	6	66.7	2	22.2	1	11.1

COMPLICATIONS AND COEXISTING DISEASES

The complications and coexisting diseases most frequently found in diabetes mellitus are diabetic coma, the various infections, cardiovascular renal disease and pulmonary tuberculosis.

The complications, sequelae and intercurrent diseases are of more serious import to the diabetic patient than is diabetes itself. It is the presence of one or more of the complicating or intercurrent diseases that makes the prognosis of the diabetic condition less favorable and interferes with the satisfactory treatment of the disease. Death of the diabetic patient is usually due to one of the complications or intercurrent infections rather than to diabetes mellitus itself.

In a previous study I [8] found that among a group of 300 diabetic patients 79 per cent gave evidence of one or more complicating or coexisting diseases. The most frequent coexisting diseases in the group studied were obesity, coma, arteriosclerosis, tonsillitis, caries of teeth, hypertension and tuberculosis. Joslin [1] refers to a group of 1,206 diabetic patients and thirty-seven patients with nondiabetic glycosuria who were admitted to the George F. Baker Clinic in 1934, 257 of whom had no complicating disease and the others giving evidence of one or more complications.

Table 7 indicates that among 1,663 diabetic patients included in the present study 1,770 coexisting or complicating diseases were noted, an average of 1.1 disabilities per patient. Among twenty-eight cases of unclassified diabetes mellitus of the group, forty-six coexisting conditions were noted, or an average of 1.6 disabilities per patient.

The most frequent coexisting conditions found among the group of diabetic patients were cardiac disease, arteriosclerosis, hypertension, chronic tonsillitis, arthritis, chronic bronchitis, psychoneurosis, obesity, active and inactive pulmonary tuberculosis, and diseases of the kidneys.

The most frequent coexisting conditions are those referable to the vascular system; 365, or 21.9 per cent of the group, gave evidence of this type of complication. Arteriosclerosis and hypertension were present to the extent of 7.1 per cent and 7 per cent respectively. Heart disease was a complicating factor to the extent of 15.6 per cent. Certain of the other coexisting diseases such as arthritis, bronchitis and tonsillitis were in no way related to diabetes mellitus.

Diseases of the endocrine glands were found to the extent of 3.2 per cent. The most frequent gland affected was the thyroid. In a number of instances there was a pluriglandular involvement.

Obesity was present to the extent of 4.4 per cent and was in some way related to the diabetic condition.

Psychoneurosis was noted in 129, or 7.8 per cent, of the cases. A careful study of these cases revealed the fact that in sixty-five instances the psychoneurosis followed the inception of diabetes mellitus. It may be assumed therefore that the diabetic disease was a direct or contributing cause of the psychoneurosis. In twenty instances the development of the psychoneurosis preceded the inception of the diabetic condition. Accordingly, the condition may be said not to be in any way related to the diabetic disease, except that the latter condition may have prolonged or accentuated the psychoneurosis. In forty-four instances it was not possible to ascertain whether a relationship between the two diseases existed.

Pulmonary tuberculosis, active and inactive, was found in 4.4 per cent of the patients. It was not much of a problem in the management of the diabetic condition.

TABLE 7.—*Principal Coexisting and Complicating Diseases*

	Total		True Diabetes	Potential Diabetes	Unclassified Diabetes	Renal Glycosuria
	Number	Per Cent				
Amblyopia	8	0.5	8	..	..	..
Anemia, secondary	7	0.4	6	1	..	..
Arthritis	156	9.4	136	15	4	1
Bronchitis, chronic	144	8.7	124	17	1	2
Colitis	22	1.3	22	..	..	..
Dental diseases	98	5.9	86	9	3	..
Diabetic coma	3	0.2	3	..	..	..
Diseases of the endocrine glands	54	3.2	40	5	9	..
Cardiovascular diseases:						
Heart disease	259	15.6	228	24	4	3
Vascular disease	365	21.9	330	26	8	1
Diseases of the eye	72	4.3	69	3	..	..
Gangrene	8	0.5	8	..	..	..
Hyperinsulinism	1	0.1	1	..	..	..
Diseases of the kidneys	58	3.5	53	4	1	..
Neuritis	32	1.9	30	1	1	..
Obesity	73	4.4	59	11	2	1
Pleurisy, chronic, fibrous	29	1.7	27	2	..	..
Psychoneurosis	129	7.8	95	28	4	2
Diseases of the skin:						
Furunculosis	7	0.4	7	..	..	..
Carbuncles	3	0.2	3	..	..	..
Diabetic ulcers	6	0.4	5	..	1	..
Tonsillitis, chronic	162	9.7	143	13	5	1
Pulmonary tuberculosis	74	4.4	65	4	3	2
Total coexisting and complicating diseases	1,770		1,548	163	46	13
Total cases	1,663		1,473	149	28	13
Average coexisting and complicating diseases	1.1		1.1	1.1	1.6	1.0

A study of the various coexisting conditions found in diabetic patients indicates that the problem of the physician in the treatment of the diabetic patient is twofold: first, the treatment of the diabetic condition and, secondly, the treatment of the complications and coexisting conditions. The complicating and coexisting conditions frequently have an unfavorable effect on the diabetic disease and on the prognosis of the case. It is the common experience of physicians treating diabetes that, no matter how well the patient is handled and how scientifically the dietetic regimen and insulin dosage are planned, the complications and coexisting diseases have an adverse influence on the therapeutic regimen.

COMMENT

This study of more than 1,600 living diabetic veterans includes two groups. One group gave evidence of diabetes during the military service, and the other group gave evidence of the disease at various intervals after discharge from the military service up to the time of this study. The survival period extending from the date of onset of the disease to the date of this study varied from six months to as long as forty-two years. These diabetic patients were treated by various regimens. In recent years, however, the treatment of the disease in the Veterans' Administration has been more uniform, owing to the standardization of its management, so that the results from now on will reflect the uniform treatment used. It must be realized, however, that while the management of the diabetic condition is standardized, the physicians treat their patients according to the indications present. Accordingly, the Veterans' Administration physicians find it necessary to deviate to a certain extent from the prescribed regimen because of individual characteristics of the diabetic patients and on account of the presence of complications or intercurrent diseases.

It would appear, therefore, that the results of the treatment of the various types of diabetes mellitus are not comparable, because of the varied regimens used in the past, and because of the existing variation in the clinical characteristics of the different cases. Accordingly, it is not possible to determine the therapeutic regimen which was found to be most effective in the treatment of this group of cases.

In reflecting on the diabetic patients included in this study, the first consideration is the classification of the diabetic disease. The study shows that the incidence of potential diabetes mellitus is higher among the group of veterans than is the experience in civilian life. It is possible that, as time passes, certain of the cases of potential diabetes mellitus will give evidence of being true diabetes mellitus and will be so classified. The incidence of unclassified diabetes mellitus is low. The reason is that, as the veterans grow older and become subjected to some of the diseases commonly associated with unclassified diabetes mellitus, the incidence of this type of diabetic condition may show an increase. The incidence of renal glycosuria is greater than in civilian experience. It is possible that some of the cases now classified as renal glycosuria may eventually be found to be cases of potential or true diabetes mellitus. Accordingly, the principal reason for the differences in the classification of the diabetic veterans as compared with civilian experience is the age of the veterans.

In this connection it is important to remember that the average age of the entire veterans' group (approximately 4,409,247) was 44 years at the time of this study and, furthermore, 93 per cent of this number, or approximately 4,193,373, were World War veterans of an average age of 43 years. More than half of the diabetic patients gave a history of the onset of the disease within the age groups 30-39 years. Eighty per cent gave evidence of the disease before the age of 40, and 20 per cent after that age. The average age of the whole group at the time of onset of the diabetic condition was 33.7 years.

These observations support the opinion of Joslin and others that diabetes mellitus is not a manifestation of old age. As a matter of fact the age of onset of the diabetic condition in this group of veterans begins to ascend with the age group 25-29, it reaches its acme in the age group 30-39, and then it begins to descend. Whether or not the future will show a change of the statistical pattern and an increase will take place in the incidence of the onset of the disease as the veterans become older, similar to civilian experience, remains to be seen. Joslin observed that in his experience the acme of the onset of the diabetic disease occurred in the age period 50-54 years, during which time 14.4 per cent of the males of his group gave evidence of the onset of the disease.

Accordingly, it would appear that if measures are to be taken to overcome the disease it would be advisable to begin in the earlier age groups rather than in the middle life period. The data in this study point to the fact that diabetes mellitus is a disease of youth as well as of middle life.

In the consideration of the survival period of this group of diabetic patients it must be emphasized that they have been under treatment for various periods and by varied regimens; some of the patients have been treated with insulin and others without it. Those who have been under treatment for a number of years have recently been on a standardized regimen. The insulin treated patients with true diabetes have survived the disease on an average 9.1 years and are now of an average age of 42 years, while the small group of insulin treated patients with unclassified diabetes mellitus have survived the disease on an average 12.8 years and are now of an average age of 40.7 years. The patients with true diabetes not treated by insulin have survived the disease on an average 7.2 years and have reached the average age of 44 years; the veterans with potential diabetes have survived the disease on an average 6.7 years and are now of an average age of 42.3 years; the veterans with unclassified diabetes have survived the disease on an average 7.4 years and are now of an average age of 44.8 years; finally, the veterans with renal glycosuria have survived the disease on an average 12.5 years and have reached the average age of 43.

The variation in the survival period of the living diabetic patients is dependent on the length of time they have had diabetic disease to the date of the study. As these cases are still under treatment, the figures are not final. It is believed that the survival period of the patients not receiving insulin will eventually exceed that of the patients on insulin. This is based on the fact that the diabetic condition of those patients not receiving insulin is milder and that a larger percentage of these cases are being controlled as the result of the dietetic regimen used. The figures representing the survival period of the various groups of diabetic veterans should therefore not be taken as indexes of the comparative potency of the various regimens used.

In studying the duration period of the living diabetic veterans one is impressed with the fact that the average duration of the disease is more than nine years. When

one realizes that patients with a fatal form of the disease formerly died after a duration of the disease of 4.8 years following intensive treatment, one must conclude that an enormous advance has been made in the management of diabetes mellitus.

Of a total of 1,473 patients with true diabetes mellitus, 84.4 per cent had been treated with insulin and 15.6 per cent by diet and other measures. It is difficult to make a comparative estimate of the relative efficacy of insulin as compared with diet in the treatment of true diabetes mellitus, since patients with the disease in a milder form were usually placed on a dietary regimen, while the patients with severe diabetes were placed on insulin.

Of the group of 1,243 cases of true diabetes mellitus treated by insulin, 30.7 per cent were controlled, 46.8 per cent were partially controlled and 22.5 per cent were uncontrolled. Of the group of 230 cases of true diabetes mellitus not treated by insulin, 63.6 per cent were controlled, 25.7 per cent were partially controlled and 10.7 per cent were uncontrolled. This confirms the previous statement that the cases on insulin are more severe than those on a dietetic regimen; therefore a comparative evaluation of the efficacy of the two regimens cannot be made from the data available in this study.

In the discussion of the coexisting diseases of diabetes mellitus it was found that certain of the disabilities were related to the diabetic condition either as sequelae or as complications; others were intercurrent and unrelated infections or diseases. The conditions that might be considered related to diabetes mellitus are cardiac disease, arteriosclerosis, hypertension, psychoneurosis and obesity. The conditions that were found to be coexisting without in any way being related to diabetes mellitus are active and inactive pulmonary tuberculosis, chronic tonsillitis, arthritis, chronic bronchitis and kidney disease.

In this connection it is well to point out that any coexisting condition, especially an infectious disease, presents a problem that must be given serious consideration in the treatment of the diabetic condition. Frequently the dose of insulin must be increased to compensate for its reduced therapeutic effect because of the coexisting infection. Then, too, mild diabetic conditions that ordinarily can be treated by a dietetic regimen require insulin in order that the hyperglycemia and glycosuria may be controlled.

In the management of diabetes mellitus it is essential that the patient be discouraged from seeking hospital care for his diabetic condition, except in the early stages of the disease, or soon after the condition is diagnosed, at which time it is necessary for him to receive hospital instruction in the salient phases of the disease, in its dietetic management, in the technic of the self administration of insulin, in the treatment of hypoglycemia, and in the prevention of gangrene. As the disease lasts a lifetime, the patient should be permitted to treat himself from the standpoint of dietetics and insulin therapy. The physician, of course, must carefully supervise the patient's efforts in this direction. The patient should, in addition, be encouraged to earn a livelihood. He should exercise and should seek useful entertainment to overcome introspection.

SUMMARY AND CONCLUSIONS

1. Of the group of 1,663 living diabetic veterans included in this study, it was found that the incidence of potential diabetes mellitus was greater than in the experience of Joslin and other observers. The explanation is that the veterans are a younger group of men of an average age of 43 years. It is possible that a number of the cases now classified as potential diabetes mellitus may eventually be found to be true diabetes mellitus. The incidence of unclassified diabetes mellitus was 1.7 per cent as compared with the experience of Joslin, who found that they constituted 10 per cent of a group of 13,000 diabetic patients. It is possible that a more direct relationship between coexisting disabilties and the diabetic condition will be established later as the veterans grow older, increasing the incidence of unclassified diabetes mellitus. The incidence of renal glycosuria is greater in this group than has been the experience of Joslin. It is possible that certain of these cases will eventually be classified as potential or true diabetes mellitus.

2. One hundred and forty-five, or 8.7 per cent, of the group gave a hereditary, familial or combined hereditary and familial history of diabetes mellitus.

3. Of the group of 1,663 diabetic veterans 850, or 51 per cent, gave evidence of the onset of the disease within the age groups 30-39 years. Furthermore, 80 per cent gave evidence of the disease before the age of 40 and 20 per cent after that age. The average age of the group of 1,663 veterans at the time of the onset of the diabetic condition was 33.7 years. The acme of the onset of the disease in the group studied appeared to be within the age group 30-34 years.

4. Of 1,473 cases of true diabetes mellitus, 84 per cent were being treated with insulin. Of twenty-eight cases of unclassified diabetes mellitus, approximately 32 per cent were on insulin therapy.

5. Of 1,252 living diabetic patients treated with insulin, 25.4 per cent have survived the disease from six months to five years, 31.5 per cent from five to ten years, 22.3 per cent from ten to fifteen years, and 20.8 per cent from fifteen to over eighteen years. The average survival period of this group of insulin treated diabetic patients to the date of this study has been 9.1 years.

Among 411 living diabetic patients who are not receiving insulin, 230 have true diabetes mellitus, 149 potential diabetes mellitus, nineteen unclassified diabetes mellitus and thirteen renal glycosuria.

Forty-five and seven-tenths per cent of the number have survived the disease from less than six months to five years, 29 per cent from five to ten years, 10.7 per cent from ten to fifteen years, and 14.6 per cent from fifteen to seventeen years or over.

Among the 230 cases of true diabetes mellitus not treated by insulin the average survival period to the date of this study has been 7.2 years. Among nineteen patients with unclassified diabetes mellitus not treated by insulin, the average survival period to the date of this study has been 7.4 years.

As these are living diabetic veterans, the average survival period for the various groups referred to will be greater as time passes.

6. Of 411 veterans under treatment for true, potential and unclassified diabetes mellitus, and also for renal glycosuria, and not receiving insulin, 72.3 per cent were controlled, 21.6 per cent were partially controlled and 6.1 per cent were uncontrolled.

Of the group of 1,243 cases of true diabetes mellitus treated by insulin 30.7 per cent were controlled, 46.8 per cent were partially controlled and 22.5 per cent were uncontrolled. Of the nine cases of unclassified diabetes

mellitus treated by insulin 66.7 per cent were controlled, 22.2 per cent were partially controlled and 11.1 were uncontrolled.

It is a fact that the diabetic cases in which insulin was not administered were of a milder type than those treated by insulin, so that a much larger percentage of the former had the disease controlled. Furthermore, larger percentages of insulin-treated cases showed partial control, and uncontrol of the diabetic condition, than were found in the cases not treated by insulin.

7. Among the total number of 1,663 diabetic patients, 1,770 coexisting or complicating diseases were noted, an average of 1.6 disabilities per patient. The most frequent coexisting disabilities were cardiac disease, arteriosclerosis, hypertension, psychoneurosis, obesity, active and inactive pulmonary tuberculosis, chronic tonsillitis, colitis, chronic bronchitis and kidney disease. Certain of the disabilities are in some way related to the diabetic condition either as sequelae or as complications. The other disabilities are merely intercurrent diseases or infections in no way related to the diabetic condition but having a profound influence on the treatment of the patients, especially those requiring insulin therapy.

DURATION OF SPERM CELL MIGRATION IN UTERINE SECRETIONS

PRELIMINARY REPORT: MAXIMUM EIGHTY HOURS

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The purpose of this report is to present a few carefully checked observations as to the length of time sperm cells retain normal morphology and migratory power (not merely viability) in the reproductive tract of women, an important subject concerning which there is much vague speculation, many unsupported and widely varying opinions, and a paucity of convincing data.

Vignes and Boros,[1] as well as Belonoschkin,[2] state that the survival of spermatozoa is not very long and probably does not exceed forty-eight hours, owing to the higher temperature of the pelvis as compared to that of the scrotum. The former, however, quote observations made by Huhner [3] in which one case is included of sperm cells living as late as 102 hours after coitus. Macomber [4] reported finding living sperm cells in the cervical secretions four days after copulation in seven cases, and as late as seven days after contact in one instance. On the other hand, Moench [5] takes the position that body temperature kills sperm cells in twenty-four hours in most cases and states that observations of longer vitality become a moral rather than a scientific issue. Hartman and Ogino admit the probability of somewhat longer survival of fecundating power. Macias de Torrès [6] and those who subscribe to the most conservative estimates of sperm cell viability are largely influenced by consideration of heat activation and cell exhaustion or by observation of sperm cell motility in the normal ejaculate or in artificial mediums. Although I have found that cervical temperatures range from 98.6 to 99.2 F., I can confidently assert that under favorable conditions large numbers of sperm cells continue in active migration in normal cervical mucus many hours beyond the time when all travel has ceased in a direct specimen collected from the same source and observed at room or body temperature. This suggests a chemical rather than a thermal explanation, which I am now planning to investigate. (At a lower temperature, 10 C., or 50 F., viability of sperm cells is said to be greatly prolonged, owing to retarded motility). In one case migration was noted in the cervical mucus at an interval six times as long as the duration of motility in the direct specimen. Stokes [7] calls attention to the fact that active sperm cells are found in the male ejaculate from two to three weeks after vasectomy and states that there is no reason to assume that the female generative organs are more hostile to sperm cells than the seminal vesicles.

Nürnberger's [8] two cases reported sixteen years ago in which living spermatozoa were found in excised tubes thirteen and fourteen days respectively after the last reported intercourse have been repeatedly quoted in subsequent literary comments. Actually, sufficient data have not been published to justify a consensus, and one hesitates to draw general conclusions from one or two cases when the apparent duration of viability is so at variance with the prevailing theory. Therefore the examiner should not be biased and his report should include such supplementary details as are required for scientific interpretation. The discovery of widely isolated sperm cells exhibiting motility without locomotion is not convincing evidence of sustained fertility.

Not only is the accumulation of reliable data in enough cases to justify general conclusions as to the survival of sperm effectiveness under normal conditions highly important to consolidate our knowledge of the sequence of events in fecundation, but it may explain otherwise irreconcilable errors in computing the date of delivery and could conceivably be relevant to certain medicolegal questions. Furthermore, this information is absolutely essential if the limitations of the safe period are to be postulated from the period of ovulation, a question now eliciting much scientific and popular interest. The practical application of this knowledge to the problems outlined must, however, ultimately depend on the determination as to whether the fecundating power of spermatozoa is lost prior to visible change in structure and cessation of migration.

Professor Hartman,[9] in an exhaustive study of ovulation in the higher primates, calculates the safe period on the assumption that the reproductive vigor of sperm cells rarely persists beyond the thirty-sixth hour. He and other animal experimentalists point out that in certain lower animals in which copulation can be controlled with regard to known time of ovulation the evidence indicates that sperm motility continues longer than the power of fecundation. Vignes and Boros quote the experiment of Dätwyler, which shows that whereas bull spermatozoa live forty-two hours in

1. Vignes, H., and Boros, E.: La période de fécondation et les périodes de stérilité physiologique, Presse méd. **42**: 1002-1006 (June 20) 1934.
2. Belonoschkin, B.: Der gegenwärtige Stand der Spermatozoenforschung, Arch. f. Gynäk. **158**: 345, 1934.
3. Huhner, Max: Diagnosis and Prognosis of Sterility in Both Sexes, Am. Med. **20**: 8699 (Feb.) 1925.
4. Macomber: Personal communication to the Maternal Health Comm., New York.
5. Moench, G. L.: Viability of Sperm in Female Genital Tract, Queries and Minor Notes, J. A. M. A. **102**: 866 (March 17) 1934.
6. Macias de Torrès, E.: Sur la vitalité des spermatozoides, Gynéc. et obst. **30**: 544-551 (Dec.) 1934.
7. Stokes, W. R.: Biological Medical Aspects of Contraception, Nat'l Comm. Federal Legislation for Birth Control, Washington, D. C., 1934, p. 56.
8. Nürnberger, L.: Klinische und experimentelle Untersuchungen über die Lebensdauer der menschlichen Spermatozoen, Monatschr. f. Geburtsh. u. Gynäk. **53**: 87-101, 1920.
9. Hartman, Carl: The Time of Ovulation in Women, Baltimore, Williams & Wilkins Company, 1936.

Ringer's solution they survive only twelve hours in the uterine secretion. There is scant evidence that the secretion of the fundus uteri in human beings is more inimical to sperm cell survival than that of the cervix. If spermatozoa can lose their fecundating power by senility without alteration in morphology or serious impairment of motility, criteria are not available for accurate evaluation at the present time and the appraisal of the semen assumes greater difficulty.

CONDITIONS FAVORABLE TO INVESTIGATION

In the human species, reliable evidence on this subject is difficult to acquire. Conditions essential for investigation of maximum sperm survival include the good health of both sexual partners, a male specimen of normal characteristics and vigor, and cervical secretion in the female which provides a favorable medium for migration. Furthermore, there is evidence that in some women conditions most favorable to sustained motility are provided for only a limited part of the menstrual cycle. Several years ago I stated that in general the most satisfactory time for postcoital study was a few days subsequent to cessation of menstruation, owing to the increased secretion of less viscid mucus at that time, a condition often absent in patients with uterine hypoplasia. The reason was not then appreciated, but Papanicolaou, Hartman and other physiologists who subscribe to midmenstrual ovulation now consider increased secretion as a phenomenon of the high follicle period.

Because of the frequency of intercourse, the prevalence of contraceptive measures and the fact that the convenience of three persons is involved, it is difficult to arrange for proper timing of the examination. In my opinion deliberate arrangement solely for experimental purposes not only invites unadmitted errors due to conflict with the sexual habits of the couple but may introduce unpredictable factors which may vitiate the accuracy of results. Honest deductions cannot be drawn without confidence in the sexual history of the patient. It is obvious that such a happy combination of biologic conditions and concatenation of circumstances is not frequently presented by a woman who is forced to consult the gynecologist.

Granting that widely varying results may be reported in individual cases because of the many factors which affect the duration of sperm cell motility, it should be possible ultimately by accumulating reliable data to substitute fact for opinion as to average and maximum survival under normal conditions of fertility.

REPORT OF STUDIES

In 1929 I [10] reported an analysis of 250 postcoital studies made one hour after coitus and described the aspirating apparatus and technic modified after that of Huhner. At that time I was inclined to agree with Huhner that active sperm cells in the cervical mucus indicated the fertility of the husband. I have for some time questioned the accuracy of this conclusion, for motile sperm cells have been found in cases in which the direct male specimen was appraised as deficient according to the present criteria of evaluation. With the onset of the depression the technic was altered to enable out-of-town patients to make preparation at home, and it was noted that satisfactory studies could be made as late as six hours after coitus and, in occasional instances in which the husband was rendered impotent by prescribed preparation, observations were successfully carried out from twelve to sixteen hours after intercourse. Thus, by evolution, my interest was recently stimulated in the later investigations.

The observations here presented were made incidental to other studies conducted under the favorable conditions previously outlined and in patients unaware of the nature of the examination, thus obviating any motive for deception. The cases reported are restricted to those in which an average of two or more well formed, actively migrating sperm cells per high power field were found in the deep cervical mucus and the patients, when interrogated subsequent to the examination, were able to fix the time of the last coitus at thirty-six hours or more before their visit. This arbitrary period was chosen because the observations of others and my own postcoital studies indicated that sperm survival in the female at periods of less than twenty-four hours was a frequent occurrence.

The term "normally migrating cells" refers to that characteristically undulating motion by which spermatozoa travel through a mucous medium in a more or less well sustained direction as opposed to the lashing tail with constantly changing direction noted in the seminal fluid, or the vibratory motion with sluggishly intermittent travel, or no change in position, noted in cervical secretion when the cell is exhausted or seriously obstructed by viscosity.

Four cases are abstracted in which migrating sperm cells were found from thirty-six to eighty hours after coitus. The report is necessarily preliminary in character as there is no reason to believe, under the conditions of examination, that the observations are exceptional or approach the potentialities of sperm survival.

CASE 1.—Mrs. E. M.,' aged 34, married two years, seen because of primary sterility, had uterine hypoplasia to a minor degree, and endometrial hyperplasia with stromal edema. Libido was reduced. There was mild hypothyroidism, but no other physical stigmas of endocrine disorder were present. The tubes were patent and menstruation was normal. The cervical mucus was highly variable as to viscosity without apparent reference to the menstrual cycle and therefore was frequently aspirated for study. Spermigration had previously varied from early failure to continuation at the twelfth hour. Feb. 28, 1933 (the fifteenth day of the cycle), normally migrating sperm cells were incidentally noted and the patient was able to fix the time of last coitus on the night of February 25, sixty hours previous to examination. Lacking precedent, the incredulity of the examiner persisted in spite of a positive patient, and the finding was simply recorded without the number of cells per field being noted. The husband was in vigorous health and a contemporary direct specimen showed a high cell count, with 88 per cent normal forms and well sustained motility not completely suspended at the twenty-fourth hour.

CASE 2.—Mrs. S. V., aged 28, was successfully treated for primary sterility associated with marked malnutrition, passive pelvic congestion, retroversion and cervical erosion, with secretion increased in amount and viscosity. Leukorrhea had persisted since early college years. One year subsequent to delivery this frail but determined patient complained of secondary sterility and insisted on more active management than the constitutional measures recommended. An appointment was made subsequent to the approaching period for restudy of spermigration. The patient came on the seventh day of the menstrual cycle without preparation and requested a tube test. Considerable clear mucus, occupying a gaping succulent cervix, was removed preliminary to insufflation and on microscopic examination from four to twelve vigorously migrating sperm cells were found per high power field. The canal was cleansed and another aspirating cannula easily passed to the cavity of the uterus, where a small amount of blood-stained mucus was

10. Cary, W. H.: Sterility Diagnosis: The Study of Sperm Cell Migration in the Female Secretions and Interpretation of Findings, New York State J. Med. **30**: 131 (Feb. 1) 1930.

obtained, with similar results. The possibility of cervical contamination is admitted. Intercourse had occurred thirty-six hours before examination and the specimens were hardly distinguishable from normal one-hour postcoital examinations. Conception apparently occurred on the eleventh day of the second menstrual cycle thereafter. This experience altered my interpretation of the earlier case and stimulated subsequent interest in this subject.

CASE 3.—Mrs. H. T., aged 27, with primary sterility but no gross pelvic pathologic condition, was examined June 27, 1935, on the ninth day of the menstrual cycle. Clear, glistening mucus was aspirated from the cervical canal incidental to other study and when examined microscopically showed from two to four well formed, normally migrating sperm cells in each field. On inquiry the patient stated that the last intercourse occurred on Sunday night, June 23, approximately eighty hours previously. Confirmation of the date was received from the husband by telephone. A contemporary study of the husband's specimen revealed the total amount subnormal (from 2 to 2.5 cc.); viscosity was variable, apparently because of undissolved mucus; the cell count was 73,000,000 per cubic centimeter; about 40 per cent of the cells were motile, with only a fair degree of traveling vigor; abnormal forms amounted to 13 per cent. The duration of motility was subnormal, showing marked reduction in five hours, from four to five cells sluggishly crossing the field at the eighth hour and almost complete subsidence at the twelfth hour. This result was confirmed by subsequent examination. Under treatment this specimen improved as to total amount and sperm count, and initial motility was considerably increased, but cessation in a direct specimen again occurred at approximately the twelfth hour. Nevertheless, two contemporary examinations of the cervical mucus made thirty-six and sixty hours after coitus (the eighth and ninth days of the cycle) revealed in the first instance as many as sixteen spermatozoa per field with 33 per cent active travelers; on the following day, in spite of previous manipulation, most fields contained from one to four migrating cells. This indicates that, although motility may be an inherent quality of the cell, duration is controlled by the medium.

CASE 4.—Mrs. X., aged 35, seen Wednesday, Nov. 20, 1935, a "few days after the period," complained of one-child sterility. This very tall, slender woman had not been well for some time, reporting a loss of 50 pounds (23 Kg.) in eighteen months. Pregnancy was desired in the hope that she might regain the excellent health enjoyed during gestation six years previously. The uterus was retroverted, evidently complicating enteroptosis. A normal cervix contained clear mucus in abundance, and this was removed for viscosity study. Microscopic examination revealed from two to four normally migrating spermatozoa in each field, and while this was demonstrated to a confrère the nurse was sent to inquire as to the time of last coitus. Because of sexual routine the patient was able to state positively that coitus occurred at approximately 6 p. m. on the preceding Sunday, sixty-four hours before her visit. As the patient was found to be suffering from hyperthyroidism the sterility study was discontinued and the husband's specimen was not examined.

Another finding of some interest but one that does not conform to specified requirements was made in a woman, aged 39, with uterine hypoplasia and scant cervical mucus slightly increased in viscosity, in which from one to three viable (motile but nontraveling) spermatozoa were found in occasional microscopic fields eighty-four hours after coitus. The husband's specimen exhibited unusual vigor. Dead or inactive sperm cells were not found in large numbers in any of these latest investigations, possibly owing to drainage in a mucous stream which vigorous cells ascend.

I have found most patients rather vague or uncertain as to the time of last coitus after a period of more than four days has elapsed. In three cases presenting favorable conditions "a week or so" after coitus, no sperm cells were found. Negative examinations are of little significance unless all factors conducive to sperm survival are known to exist. Some form of contraception is practiced by most patients unless they are consulting the physician for sterility, and in this group conditions unfavorable for this study are frequently met.

It should be stated that this contribution is offered in the hope of stimulating the publication of further data relevant to this important question.

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OBSERVATIONS ON THE VARIATIONS IN BILE PRESSURE IN THE HUMAN BILIARY TRACT

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My purpose in this paper is to present some changes noted in the pressure of bile in the human biliary tract. The fact that these observations were made in the course of an examination of a patient for another purpose, and that subsequent review of the literature gives no similar record of bile pressure in the human being, leads me to think that perhaps these are original observations.

The patient who recorded these pressures was a man, aged 78, who had been jaundiced for more than two years. I operated on him, Jan. 26, 1934, with a local anesthetic and found a benign stricture of the common bile duct at the ampulla of Vater. The gallbladder was greatly distended with 650 cc. of clear light brown bile. The liver was greatly enlarged and intensely bile stained. The common bile duct was opened, explored with the finger and a probe 0.5 cm. in diameter forced through the ampulla into the duodenum. I then performed a cholecystogastrostomy and placed a T tube in the common duct.

The patient had a stormy convalescence, during which time his immediate direct Van den Bergh reaction, with 18.5 mg. of bilirubin per hundred cubic centimeters of blood serum, observed before operation, fell to normal. Bile was drained continuously through the T tube for several weeks and on March 9 he was discharged from the Mercy Hospital with the tube in place, closed with a small screw clamp and later a wooden plug. Bile pigment had meanwhile appeared in the stools and the icterus, with its accompanying pruritus, for relief of which he had sought operation, had disappeared.

Because of his age and general condition and the fear of the often reported ascending infection of the biliary tract in postoperative cholecystogastrostomy cases, I hesitated to remove the T tube from the common duct. From it at intervals, however, clear yellow bile was withdrawn, which showed at times a slight mucous sediment. No sign of infection made its appearance. However, there was always the question from the patient of how long he would have the tube.

I had the idea that, if the pressure of bile in the T tube was high, its removal would be followed by a chronic bile fistula and early death. As generally known, either following cholecystostomy, in the presence of obstruction of the cystic duct, or choledochostomy, in obstruction of the common duct, if the obstruction has been removed and a clear flow of bile is obtained, the bile fistula closes promptly. This case

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was complicated by the presence of an unrelieved obstruction at the region of the ampulla, as demonstrated by the injection of 15 per cent sodium iodide solution through the T tube (fig. 1) and the cholecystogastrostomy.

The patient was doing very well, so the T tube was left in the common duct. The bile was draining very well through the cholecystogastrostomy and in case this anastomosis opening became obstructed, I considered the well organized fibrous tract around the T tube a potential anastomotic duct, which could be implanted into the bowel.

TABLE 1.—*Common Duct Bile Pressure*
Measure in Inches of Physiologic Solution of Sodium Chloride

9/7/34 Time	Inspiration, Average 6.38		Expiration, Average 5.7	Comment
1:20	7.0		6.5	
1:25	7.25	*14.0	6.75	*Cough (1)
1:30	7.25		6.75	
1:40	7.0		6.5	
1:50	6.25		5.5	
2:00	6.75	*16.0	6.0	*Cough (2)
2:10	5.5		4.75	After coughing
2:20	7.25		6.5	
2:30	6.0		5.5	
2:40	6.5		5.75	
2:50	5.75	*8.0-**6.5	5.25	*Deep inspiration-**Expiration (3)
3:00	6.0		5.25	
3:10	5.75		5.0	
3:20	6.5		5.5	
3:30	5.75		4.75	
3:40	6.0	*15.0	5.5	*Laughing (4)
3:50	6.75		6.25	
4:00	7.0		6.25	After cream, milk and butter
4:05	6.25		5.25	
4:10	5.75		5.0	Desires to void
4:15	5.75	*20.0	5.25	*Cough (5)
4:25	13.5		12.5	Standing

The numbers in parentheses refer to corresponding numbers in figure 3.

In a further effort to determine the risk of removing the T tube, I thought that if the pressure in the tube was not high and since the patient was ambulant, if it was no higher when he stood erect than when he lay down it might safely be removed.

Sept. 7, 1934, I arranged a manometer with a 4 mm. inside diameter and a scale in inches (fig. 2) for the measurement of bile pressures. This was connected with the T tube in the common bile duct. The diameter of the manometer and the connections and the T tube was approximately the same. The connections of the system were filled with physiologic solution of sodium chloride to exclude air, and the bottom of the manometer was fixed at a level as nearly approximate as possible to that of the common bile duct, with the patient lying on his back.

The following observations were recorded on the fluctuations of the level of the pressure in the common bile duct as registered on the manometer:

Analysis of record of pressure variations is given in table 1 and figure 3. The variations in pressure as noted on normal inspiration and expiration were recorded every ten minutes. The average of the pressure readings on inspiration and expiration, with the exception of the wide fluctuations noted, so as to arrive at an average pressure of bile in the normal, quiet resting patient, lying on his back, in each of these respiratory phases was calculated. For normal inspiration, this amounted to $6^{38}/_{100}$ inches, or 159.5 mm. of bile. Since the specific gravity of physiologic solution of sodium chloride and bile in the common duct is approximately the same, and discounting the difference in viscosity of the two solutions because of the short distance traveled in the excursion of the fluid level in the manometer, certainly within the error of our crude method, this figure was considered bile pressure. The corresponding average pressure on the manometer on expiration, which would more nearly represent the normal tension of the bile in this system, uninfluenced by the extrinsic factor of respiratory effort, was $5^{7}/_{10}$ inches, or 142.5 mm. of bile. This figure may then be taken as the approximately normal pressure of the bile in the common duct in this patient, in whom the biliary tract is not intact because of the closed sphincter of Oddi and the substituted outlet of cholecystogastrostomy, with a T tube in the common bile duct, leading to the exterior of the body.

The difference in pressure of 17 mm. of bile therefore represents in this instance the increase in pressure in this biliary tract, i. e., the common duct, produced by a normal inspiration. The variations in pressure in the biliary tract during the course of these observations, as noted in table 1 and figure 3, are small and the pressures tend to stay at a fairly constant level.

The exceptional variations in tension under the influence of other extrinsic factors were noted as follows: When the patient took a deep breath the pressure was raised both on inspiration and on expiration; on deep inspiration, 8 inches; on expiration after a deep inspiration, 6½ inches. When the patient coughed, the pressure rose to 14 inches, or 350 mm., and the pressure returned quickly to normal, so that in ten minutes it was at its previous tension. Another cough raised the pressure to 16 inches, or 400 mm. After this hard cough there was an appreciable lowering of tension in the bile tract, as noted. The pressure then on inspiration measured 5½ inches and on expiration 4¾ inches.

TABLE 2.—*Common Duct Bile Pressure*
Measure in Inches of Physiologic Solution of Sodium Chloride

10/26/35 Time	Inspiration Normal Av. 6.53	Inspiration Deep Av. 8.8	Expiration Normal Av. 5.5	Expiration Deep Av. 5.58	Comment
10:40	6.5	9.0	5.5	5.5	
10:45	6.75	9.5	5.75	6.0	Leg moved
10:50	7.5	10.0	6.25	6.5	Right leg flexed (1)
11:00	6.75	9.0	5.75	6.0	
11:05	6.5	8.5	5.0	5.5	
11:10	6.5	8.5	5.5	5.0	
11:15	6.5-*7.0	8.5	5.0	*6.25-5.5	*Talking (2)
11:20	6.5	9.5	5.0	6.5	
11:25	6.5-*10.0	9.0	5.5-*7.5	6.0	*Restless (3)
11:30	7.25-*14.0	9.5	6.0-*7.0	6.0	*Cough (4)
11:35	5.5	7.0	4.5	5.0	After coughing
11:40	5.5	6.5	4.75	4.5	Very quiet
11:45	6.5-*7.5	8.5	5.25-*6.0	5.75	*Talking (5)
11:50	6.5-*7.5	8.5	5.5-*6.5	5.5	*Restless (6)
12:00	6.5-*11.0	10.0	5.5-*7.5	6.5	*Restless (7)
12:05	7.0	10.5	5.5	6.0	Eating
12:10	7.5	11.0	7.0	7.5	After eating
12:15	7.0	9.0	6.5	5.5	
12:20	6.5	9.0	5.75	6.0	
12:25	7.25	10.0	6.0	7.0	Right leg elevated
12:30	8.0	10.0	7.25	6.5	
12:35	13.5	17.0	11.5	12.0	Sitting up
12:40	12.25	15.0	10.5	11.0	Sitting up
12:45	11.25	12.25	10.0	10.25	Standing
12:50	6.5	8.5	5.5	5.75	Lying down
12:55	6.5	9.0	5.5	5.0	Lying down

The numbers in parentheses refer to corresponding numbers in figure 4.

This effect was small but may indicate that the extreme elevation of the pressure on coughing may have caused a discharge of bile from the tract through its exit into the stomach sufficient to account for the lowering of the pressure. Another cough raised the pressure to 20 inches, or 500 mm.

Laughing raised the pressure to 15½ inches, or 387.5 mm. The patient was fed a fat meal and there

was apparently a slight rise in pressure. This rise may have been occasioned by increased peristalsis in the stomach or some other factors. This rise was followed by a fall in pressure. Considering the method and the percentage of error possible, this variation was not considered significant.

At this time I had the patient stand and the pressure rose to 13½ inches on inspiration and 12½ inches on

Fig. 1.—Sodium iodide injection of biliary tract.

expiration. This elevation of pressure in the duct, in the erect position, led me to postpone the removal of the T tube.

The patient continued for a year with the tube, experiencing slight inconvenience. No leakage of bile occurred around the tube. However, he was sufficiently annoyed to want the tube removed.

Oct. 26, 1935, another series of pressures was estimated by the same method. In this series of observations, as seen in table 2 and its accompanying graph (fig. 4), the pressure on normal and deep inspiration and the pressure after a normal and after a deep inspiration were recorded as well as the variations in pressure produced by other factors.

It was found that the average pressure on normal inspiration was $6^{53}/_{100}$ inches, or 163.25 mm. of bile. This figure is approximately the same average pressure as in the preceding series of similar observations and serves as a fairly good check on the method, the former comparable reading being 159.5 mm. of bile. The average pressure on deep inspiration was $8^{8}/_{10}$ inches, or 220 mm., of bile. The average pressure in this series after normal inspiration, i. e., normal expiration, was 5½ inches, or 137.5 mm., and after deep inspiration was $5^{58}/_{100}$ inches, or 139.5 mm., of bile. These pressures were very nearly the same and compare closely to the observations under similar circumstances in the series a year previously, which were $5^{7}/_{10}$ inches, or 142.3 mm., of bile. The figures for expiration in the two series of observations are approximately the same and an average of the three average figures, or 139.8 mm. of bile, may be taken as the normal tension of the bile in the common duct in the patient's biliary tract.

Significant changes in pressure were also recorded on moving the patient's right leg, talking, coughing and restless moving about of the patient on the table, as seen in table 2 and figure 4. When the patient sat up on the table, moving the manometer to correspond to the change in position of the common duct, the bile pressure was increased to 13½ inches, or 337.5 mm., on normal inspiration, and 17 inches, or 425 mm., on deep inspiration, with a return to 11½ inches, or 287.5 mm., on expiration. These pressures were higher than those produced by the patient's standing. This is probably due to the fact that in the sitting position there was considerably more compression of the contents of the abdomen.

These elevations of pressure within the biliary tract of the patient, as recorded, caused me to be very hesitant to disrupt a working scheme in an elderly patient, subject to the possible accidents to his altered biliary tract. He was allowed to keep his T tube until Jan. 13, 1936, when, because of its being a possible cause of some epigastric discomfort, it was removed without difficulty and found to be open in good condition. Bile drained profusely from the opening until January 18, five days later, when it stopped. The wound has been healed since, without further drainage of bile. Bile appears regularly in the stool and there is no icterus.

The results obtained in these two series of observations on the variations in pressure in the human biliary tract, altered as it may be in this patient, are interesting when compared with the various observations made on the biliary tract pressures in dogs, particularly experimental work done on animals to determine the various forces which combine to cause a flow of bile from the liver cells into the duodenum. In this case the factor of sphincter control of the bile

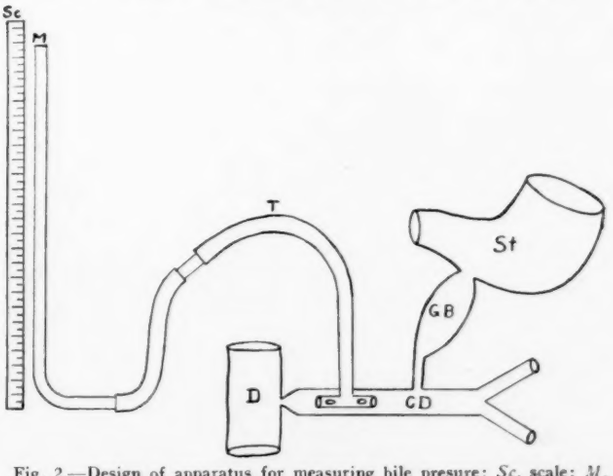

Fig. 2.—Design of apparatus for measuring bile presure: *Sc*, scale; *M*, manometer; *T*, tube; *CD*, common duct; *St*, stomach; *D*, duodenum; *GB*, gallbladder.

entering the duodenum may be disregarded, as shown by the injection of the radiopaque sodium iodide solution. The duration of the patient's jaundice for a period of two years, however, would suggest that the obstruction at the ampulla of vater was not complete. The fact that there was found at operation fairly

normal-appearing pigmented bile, rather than white bile,[1] in the greatly enlarged gallbladder, the walls of which were not disabled beyond the point of some degree of compensatory resorption, would suggest this conclusion. Judging, however, from these factors and the extensive bile staining and enlargement of the liver, the pressure necessary for bile to flow into the duodenum through this narrowed opening must have been very high. That the obstruction was becoming greater

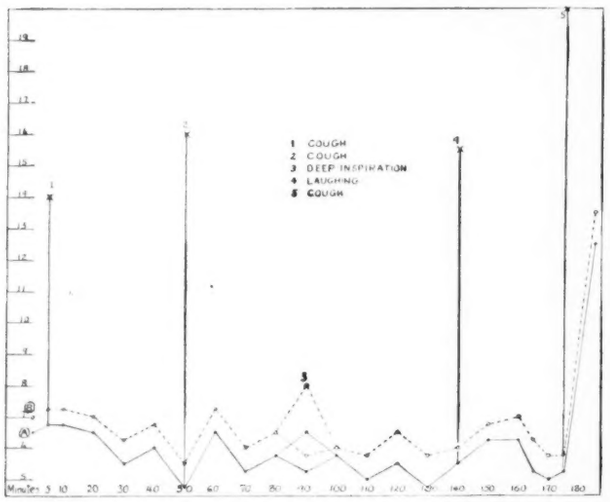

Fig. 3.—Bile pressures, Sept. 7, 1934: *A*, expiration; *B*, inspiration.

is proved by the intensification of the patient's icterus and the rise in the bilirubin in the blood from 12.5 to 18.5 mg. in the two months preceding operation. The fact that no radiopaque solution flowed into the duodenum at the time of the visualization of the bile tract is suggestive that the ampulla was closed but further not conclusive, since the observations under the fluoroscope and the subsequent taking of films were continued for too short a time to tell whether or not some of the fluid might have entered the duodenum. However, since the hepatic ducts and the gallbladder were filled with the contrast medium, without the appearance of the iodide solution in the duodenum the ampulla of Vater must be rather firmly closed. The duodenum was not opened at the operation and the ampulla was not directly observed. Sufficient damage had been done the patient. The difficulty with which a probe was passed through the ampulla into the duodenum and the absence of any palpable stone or tumor, together with the fact that the patient still lives without icterus or palpable evidence of abdominal tumor, might be considered sufficient evidence of the presence of a benign stricture. Thus it may be assumed that in this case the ampulla of Vater is closed and thereby eliminated as a factor in the control of pressure variations in this biliary tract.

Experimental evidence of the rôle of the gallbladder in controlling bile pressure may then be considered. Introduction of a metal cannula into the fundus of the gallbladder in the experimental animal has apparently not interfered with its contractile power. Potter and Mann [2] found a rise in pressure of 68 mm. of water in the gallbladder of the dog after a milk feeding, as compared to a rise of 35 mm. in the common duct. Therefore tonus, elastic recoil, as shown by Copher, Kodama and Graham,[3] and contractile power of the gallbladder, as demonstrated by Ivy,[4] may be considered in the presence of a cholecystogastrostomy.

The secretory pressure of bile, as measured in the dog by Winkelstein and Aschner,[5] amounted to from 60 to 70 mm. of bile. This, then, is an additional factor to be considered in maintaining the pressure recorded in the common duct.

Elman and McMaster[6] observed in a normal, unanesthetized dog that from 100 to 120 mm. of bile pressure produced a flow of bile in the duodenum from four to twelve hours after feeding, but that in a fasting dog between 200 and 300 mm. of bile pressure was necessary to cause a flow of bile into the duodenum. Potter and Mann [2] observed that the average biliary pressure in the quiet, intact, unanesthetized dog was 120 mm. of water, which they considered bile pressure. These men also record the resistance of the sphincter of Oddi to passage of bile into the duodenum as observed by others to vary from 60 to 625 mm., the average pressure, excepting the highest one, recorded by Oddi himself (625 mm.), being 158.5 mm. Therefore in dogs under experimental conditions a pressure of from 60 to 158.5 mm. of bile has been found necessary to produce a flow of bile through the sphincter of Oddi.

Regulation of flow of bile through the cystic duct has been studied; since it is a factor in this case, although the physiologic mechanism has been disturbed, the experimental observations are of interest. Winkelstein and Aschner [5] state that the cystic duct offers a resistance of 30 mm. of bile, while Rous and McMaster [1] found that a pressure of 60 mm. of bile was sufficient to fill the dog's gallbladder through the cystic duct.

In this pressure system the control of the opening between the gallbladder and the stomach remains to be considered. Its size is unknown and its variation in position and size under peristaltic movements and size of the stomach and posture of the individual is a matter of speculation. Bile has occasionally been regurgitated

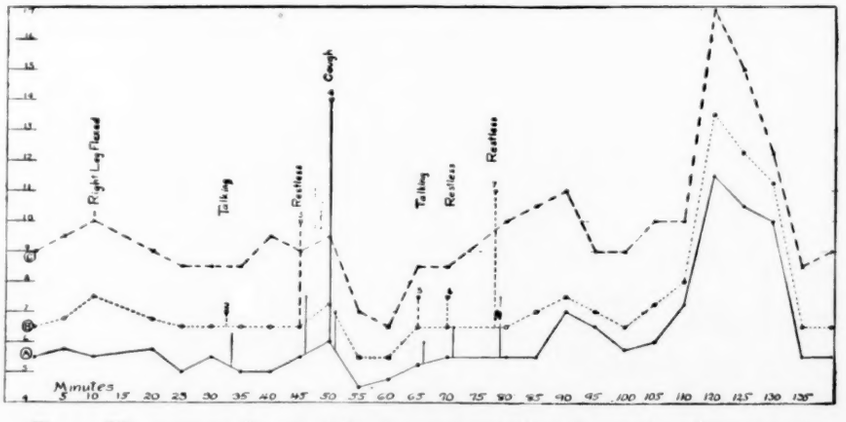

Fig. 4.—Bile pressures, Oct. 26, 1935: *A*, normal expiration; *B*, normal inspiration; *C*, deep inspiration.

1. Rous, Peyton, and McMaster, P. D.: J. Exper. Med. **34**: 47 (July) 1921.

2. Potter, J. C., and Mann, F. C.: Am. J. M. Sc. **171**: 202 (Feb.) 1926.

3. Copher, G. H.; Kodama, S., and Graham, E. A.: J. Exper. Med. **44**: 65 (July) 1926.

4. Ivy, A. C.: Physiol. Rev. **14**: 1 (Jan.) 1934.

5. Winkelstein, A., and Aschner, P. W.: Am. J. M. Sc. **171**: 104 (Jan.) 1926.

6. Elman, Robert, and McMaster, Philip: J. Exper. Med. **44**: 151 (July) 1926.

from the patient's stomach. It has appeared regularly in the stool and there has been an absence of icterus.

It might be concluded, concerning the anastomotic opening, that the flow of bile into the stomach is regulated by the secretory pressure of the bile, the resistance of the cystic duct to its passage, the elasticity, tonus and contractile power of the gallbladder, the size of the opening, the peristalsis of the stomach and the extrinsic factors observed on the pressure records.

Since the mechanism provided at operation for this patient works and the bile pressures in man necessary to discharge bile into the duodenum or stomach are not recorded, the only figures with which to compare those recorded here are the figures for the experimental dog. Thus the average pressure in the human common duct, under these circumstances, in normal expiration is apparently 139.8 mm. of bile. With deep inspiration this pressure may rise to 220 mm. of bile, a rise in pressure of 80.2 mm. of bile. This increase in pressure in the human common bile duct, if the rise as recorded necessary in the dog is comparable, hardly suffices to force bile into the duodenum or stomach. However, on coughing, laughing, sitting up and standing, a rise of approximately 250 mm. to 260 mm. of bile in the human being would probably promote the flow of bile into the duodenum or stomach.

Might it not be too trite to suggest, in view of the rise in pressure in the biliary tract, in coughing, laughing and standing, that in our smoky Pittsburgh atmosphere our chronic coughs may have the virtue of alleviating to some degree the melancholy of our dark winter days by relieving us of some of our bile; that the old adage of "laughter with our meals makes for better digestion" has a physiologic basis, not only in the release of inhibitory impulses but also in increasing the flow of bile into the digestive tract? Finally, may we not consider our standing hot dog lunch counters a great advance from the time of the Romans, who ate reclining, to their detrimental disengorgement?

The clinical value of these observations is problematic. Certainly with refinement in technic and a greater number of records in cases in which the biliary system is intact except for a tube in the gallbladder or common duct, with simultaneous observations of the movements of the duodenum and the appearance therein of bile, the normal response to food, chemicals and drugs and other extrinsic factors may be studied and a better understanding of the human mechanism of the flow of bile achieved.

CONCLUSIONS

1. Certain variations have been noted in the pressure of bile in the human common bile duct.
2. Extrinsic factors have been demonstrated which may influence the flow of bile.
3. The healing of biliary fistulas is accomplished by factors other than the lowering of pressure within the biliary tract.

Diagnosis of Yellow Fever.—I can remember when it was believed that an expert could make a diagnosis of yellow fever even in mild cases just from the clinical symptoms. After studying the disease in an endemic center from 1906 to 1910, I gave it up and said that I at least could not. Today we know that in endemic centers it frequently happens that the majority of cases occurring in the local population are unrecognized. Time and again in recent years by blood surveys and protection tests it has been found that yellow fever has occurred off and on for years in certain localities without its presence having been known.—Lloyd, B. J.: Public Health Significance of Our Newer Knowledge of Yellow Fever, *South. M. J.* **29**:533 (May) 1936.

PRESSURE IN THE COMMON BILE DUCT OF MAN

ITS RELATION TO PAIN FOLLOWING CHOLECYSTECTOMY

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The importance of the function of the sphincteric mechanism at the lower end of the common bile duct and the clinical application of knowledge concerning it in the management of disease of the biliary tract have of late been receiving a great deal of attention. Ivy and Sandblom [1] in this country, Schmieden and Niessen [2] in Germany and Pavel [3] in France have been in the fore in the elucidation of the types of biliary dyskinesia and of the symptoms which they produce. These men have applied knowledge gained from animal experimentation to clinical studies of cases and to operative results.

We have interested ourselves in direct measurement of changes in physiologic functions of the common bile ducts of human beings who have disease of the biliary tract. With the consent of the persons concerned, we have determined changes in pressure in the common bile duct of individuals into whose common bile duct a T-tube has been inserted previously, in the course of operation, for prolonged biliary drainage. Reports of direct measurement of pressure in the common bile duct of man have not been found in the literature. Choledochography has proved to be a valuable adjunct to our studies.

The existence of a sphincter, the first description of which by Gage [4] was later amplified by Oddi,[5] or the exact anatomic nature of a sphincter, is not our concern. The functional capacity of the sphincteric mechanism at the lower end of the common bile duct, and not the question of exactly what muscle fibers are included in its structure, has engaged our attention.

REVIEW OF RELEVANT LITERATURE

Judd and Mann [6] in 1917 drew attention to the importance of the sphincter of the common bile duct in surgical conditions when they demonstrated the dilatation of the common bile ducts of dogs that follows removal of the gallbladder. They showed that this dilatation does not occur when the sphincter of the common bile duct is cut at the time of cholecystectomy. Changes of pressure in the common duct were measured by Potter and Mann [7] by inserting a T-tube into the common bile duct of the dog. They discovered that pressure in the duct increased markedly following cholecystectomy. They found that rhythmic

From the Division of Surgery, the Mayo Clinic.
From the surgical service of Dr. Waltman Walters.

1. Ivy, A. C., and Sandblom, Philip: Biliary Dyskinesia, Ann. Int. Med. **8**: 115-122 (Aug.) 1934.
2. Schmieden, V., and Niessen, H.: Dyskinesie der Gallenwege (Cholepathia spastica) und Chirurgie, München. med. Wchnschr. **80**: 247-250 (Feb. 17) 1933.
3. Pavel, I.: Ictère par obstacle functionnel dû au spasme du sphincter d'Oddi avec examen anatomique, Presse méd. **2**: 1948-1950 (Dec. 24) 1932.
4. Gage, S. H.: The Ampulla of Vater and the Pancreatic Ducts in the Domestic Cat (Felis Domestica), Am. Quart. Micro. J. **1**: 128; 169, 1879.
5. Oddi, Ruggero: D'une disposition à sphincter spéciale de l'ouverture du canal cholédogue, Arch. ital. d. biol. **8**: 317-322, 1887.
6. Judd, E. S., and Mann, F. C.: The Effects of Removal of the Gallbladder: An Experimental Study, Surg., Gynec. & Obst. **24**: 437-442 (April) 1917.
7. Potter, J. C., and Mann, F. C.: Pressure Changes in the Biliary Tract, Am. J. M. Sc. **171**: 202-217 (Feb.) 1926.

changes in pressure occurred and that the pressure could be influenced by the diet of dogs; that milk caused the highest pressure, that dog biscuits gave an intermediate reaction, and that fasting was accompanied by the lowest pressure. Giordano and Mann [8] showed that alkali placed in the duodenum increased, and that acid decreased, the resistance of the sphincter of the common bile duct of the dog. They also demonstrated

Fig. 1.—Apparatus connected to T-tube. This picture was taken shortly after administration of morphine; the fluid in the manometer has started to rise.

specimens obtained at postmortem examination of human beings who had had cholecystitis and duodenal ulcer; the musculature of the sphincter had undergone hypertrophy.

Physostigmine, pilocarpine, nicotine and acetylcholine have been found to increase pressure in the duct, whereas scopolamine, atropine and epinephrine decrease it.[9] Kitakoji[10] found that morphine causes the sphincter to contract, a fact that has been of much use to us.

INVESTIGATIONS THAT LED UP TO THE PRESENT STUDY

In the autumn of 1934, Thiessen and one of us (Walters[11]) carried out studies on the physiology of the common bile duct by injecting into it bromipin, a substance that is opaque to roentgen rays. These studies were reported in detail at the meeting of the Interstate Postgraduate Medical Assembly in 1935. Following introduction of bromipin, if there was any persistent pancreatitis with narrowing of the bile duct, any reflux of bile into the duct of Wirsung or any disturbance of the sphincter of Oddi, roentgenograms gave evidence of the conditions.

It has been recognized that residual pancreatitis might lead to recurring attacks of abdominal pain, like that of biliary colic, but narrowing of the pancreatic portion of the common duct caused by swelling of the pancreas has not been emphasized as a mechanism by which the attacks are produced. Generally speaking, too little attention has been given to the effect of reflux of bile into the duct of Wirsung as a causative factor of pancreatic swelling. Similarly, abnormal function of the sphincter of Oddi, either from inflammation, spasmodic contraction or fibrotic stenosis, has not received the attention and study which it deserves as a factor in producing biliary stasis.

METHOD OF PRESENT STUDY

These studies were made in cases in which the gallbladder had been removed and a T-tube had been left in the common bile duct for drainage. The apparatus for measuring changes in pressure in the common bile duct consisted of a spinal fluid manometer fitted in the vertical position on a frame attached to a ring stand (fig. 1). The manometer was connected to the T-tube in the common duct by means of a rubber tube. This rubber tube was interrupted in the middle by a glass Y-tube, one limb of which was attached to the rubber tube on the manometer, while the other was connected

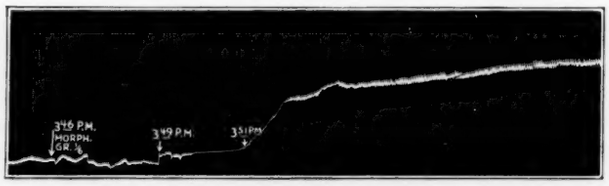

Fig. 2.—Intraductal pressure following administration of one-sixth grain (0.01 Gm.) of morphine subcutaneously.

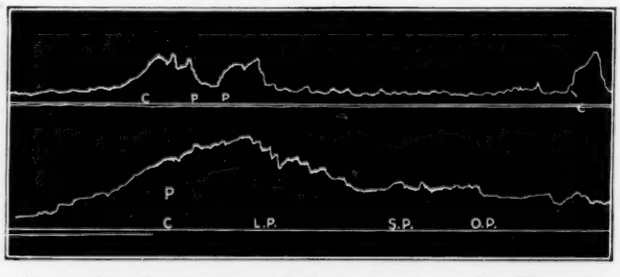

Fig. 3.—Intraductal pressure during spontaneous pain: Three short cramps represented in the upper line; one long pain in the lower. *P*, pain; *C*, cramp; *L. P.*, less pain; *S. P.*, slight pain; *O. P.*, no pain.

to the rubber tube that led to the T-tube in the common duct. The stem of the glass Y-tube was attached by means of a rubber tube to a bottle which acted as a reservoir for physiologic solution of sodium chloride. This type of bottle has been described previously by Osterberg and Little.[12] The rubber tubes were filled with saline solution from the bottle, and the rubber

8. Giordano, A. S., and Mann, F. C.: The Sphincter of the Choledochus, Arch. Path. & Lab. Med. **4**: 943-957 (Dec.) 1927.

9. Brugsch, Theodor, and Horsters, Hans: Cholagoga und Cholagogie, Arch. f. exper. Path. u. Pharmakol. **118**: 267-312, 1926. Burget, G. E.: The Regulation of the Flow of Bile: II. Effect of Eliminating the Sphincter of Oddi, Am. J. Physiol. **79**: 130-134 (Dec.) 1926. Grebe, Arnold: Erweiterung unserer Kenntnis über die Wirkung "ruhigstellender" Pharmaka auf die Funktion des extrahepatischen Gallenwegssystemes, Ztschr. f. klin. Med. **115**: 446-453, 1931. Shi, K.: The Influence of the Gallbladder, Oddi's Muscle and the Duodenum upon the Outflow of Bile: Injection of Visceral Nerve Poisons and Pituitrin, Japan. J. Gastroenterol. **3**: 19-25 (April) 1933. Westphal, Karl: Muskelfunktion, Nervensystem und Pathologie der Gallenwege, Ztschr. f. klin. Med. **96**: 22-150, 1923.

10. Kitakoji, Yoshiharu: Studien über die Funktionen der Gallenblase und des Oddischen Muskels in Bezug auf die Absonderung der Blasengalle: I. Mitteilung. Ueber den Einfluss von Nervengiften auf die Funktionen der Gallenblase und des Oddischen Muskels, Nagoya J. M. Sc. **5**: 24-29 (Nov. 20) 1930.

11. Walters, Waltman, and Thiessen, N. W.: Visual Methods of Studying the Physiology of the Common Bile Duct: I. The Problem of Pancreatitis and Sphincteritis, Proc. Staff. Meet., Mayo Clin. **9**: 772-775 (Dec. 19) 1934.

12. Osterberg, A. E., and Little, G. G.: An Apparatus for the Preparation and Intravenous Administration of Various Fluids in Large Quantities, Proc. Staff Meet., Mayo Clin. **10**: 241-245 (April 17) 1935.

tube leading from the reservoir was then clamped off. This left a continuous column of fluid from the common duct to the manometer.

To take the readings, the reservoir bottle was held in the hand at a low level. It was gradually elevated until the solution was flowing freely, which was indicated by air bubbling up into the bottle. The pressure at this point was that necessary to force the solution into the duodenum. This is referred to as the "perfusion" pressure. When the tube to the reservoir bottle was clamped off, the pressure as recorded in the manometer fell at a variable speed to a fixed level.

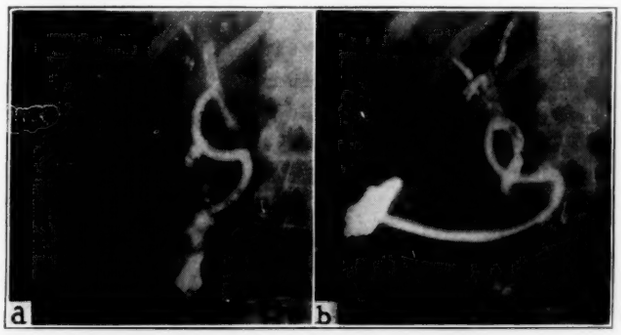

Fig. 4.—Choledochograms: *a*, without morphine; *b*, seven minutes after administration of morphine.

which is referred to as the "intraductal" pressure. As the pressure in the common duct increased, the fluid in the manometer rose. For the purpose of making permanent records, a U-shaped tube in the form of a water manometer, with a float and writing stylet on one side, was substituted for the spinal fluid manometer; changes in pressure were recorded on a smoked drum.

The method used for making roentgenograms of the common duct was as follows: A sterile 10 cc. Luer syringe was fitted into the end of the T-tube and the bile was aspirated. Five cubic centimeters of lipoiodine was injected and a roentgenogram was made. The opaque substance usually went in without much pressure. The process was repeated for verification five minutes later. Morphine, one-sixth grain (0.01 Gm.), was then given subcutaneously and the pressure manometer was connected to the T-tube. When the full morphine effect was present, as was indicated by the reading of pressure, the manometer was disconnected. Bile flowed freely from the T-tube for a time. The content of the T-tube was then aspirated in order to remove as much bile as possible from the biliary system.

The opaque substance was then injected slowly. From 3 to 5 cc. went in easily, at which point a sensation of pressure was transmitted to the hand from the syringe. Injection was then stopped and a roentgenogram was made.

RESULTS

Studies of pressure were made on fifteen occasions; the subjects were eight different patients and all of them were at rest while the studies were in progress. The pressure, measured by a column of fluid above the level of the abdominal wall, ordinarily is between 0 and 30 mm. of water. Respiratory excursions cause the pressure to rise from 5 to 10 mm. of water. A more detailed report of the intraductal pressure in different conditions will be given later.

It was found that morphine sulfate, one-sixth grain (0.01 Gm.), given subcutaneously, produced an increase in intraductal pressure on fourteen occasions (fig. 2). Pressure began to rise from two and a half to four minutes after administration of morphine. It rose rapidly and reached a plateau from ten to fifteen minutes after the injection.

Rise in pressure was associated with constant pain in one case. This pain was situated in the right upper abdominal quadrant and extended around the right subcostal margin. Pain also was present at the same time in the right scapular region and extended up toward the right shoulder. This was the same type of pain from which this patient had suffered since removal of her gallbladder a year previously. She would wake after midnight, frequently in pain. Attacks were often severe, lasted as long as an hour, and were accompanied by nausea. In addition, she complained of frequent cramps in the right upper abdominal quadrant, which came and went during the day.

The manometer was connected to the T-tube on two separate days and was left in place for several hours in order to get a reading in the course of an attack of pain. In all, five attacks of pain occurred in the course of the study, and accompanying each was a rise in pressure (fig. 3). The duration and severity of the pain corresponded in each case with the size of the pressure curve. On one occasion the pressure was as high as 160 mm. of water. The manometer was so situated that the patient was unable to see it, ruling out, as far as possible, any psychologic element.

The pain that followed administration of morphine began shortly after the pressure started to rise. It became increasingly severe in the next ten minutes and then gradually became less severe, no doubt because of the analgesic action of morphine on the higher nerve centers.

Pain persists throughout the whole time of the rise in pressure, which is about two hours. Because of inconvenience to patients, the pressure curve was not followed to its conclusion on more than two occasions. The pressure rises, under the influence of morphine, from 0 to 200 or 350 mm. of water. The perfusion pressure is also elevated, usually from 140 mm. to 400 or 600 mm. of water. The point and mode of action of

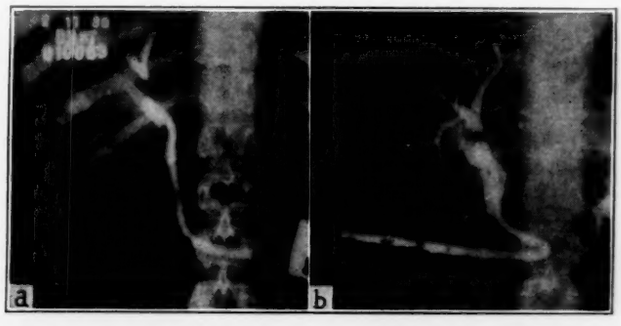

Fig. 5.—Choledochograms: *a*, without morphine; intraductal pressure at 20 mm. water, and *b*, thirty-one minutes after administration of one-sixth grain (0.01 Gm.) of morphine subcutaneously; intraductal pressure at 120 mm. water.

morphine on the biliary system offers a large field for speculation. This much evidence is available: 1. Fluid can be made to flow from the common bile duct into the duodenum after administration of morphine only by increasing the pressure. In other words, the perfusion pressure is increased. 2. Roentgenograms made before administration of morphine give evidence of rapid emptying of the common duct; the opaque medium usually is found in the duodenum. Roentgenograms of the same patients after administration of morphine give evidence of distention of the common duct.

Opaque substances remain in the hepatic ducts and smaller branches of the biliary tree and the lower end of the common duct tapers to a sharp point, suggesting muscular spasm; the picture is not unlike that of the esophagus in the presence of cardiospasm (figs. 4 *a* and 4 *b* and figs. 5 *a* and 5 *b*).

Since muscle spasm suggested itself as the main factor in the phenomenon described, drugs that might cause relaxation were tried to counteract the spasm caused by morphine and subsequently to relieve the patient's pain. A therapeutic dose of the relaxing drug was given in order to be sure that it did not produce a rise in pressure. Then morphine, one-sixth grain

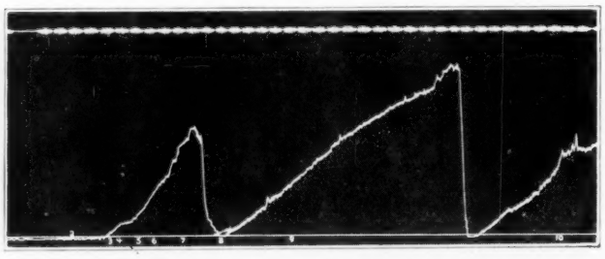

Fig. 6.—Effect of amyl nitrite at the height of pain that followed administration of morphine. Inhalation of amyl nitrite brought a complete drop in pressure and relief of pain. As the effect of amyl nitrite wore off, morphine again produced an increase in pressure, which was again relieved by inhalation of amyl nitrite. (Each stroke of the timer represents five seconds; each group of strokes represents one minute.) At 2, morphine was given; at 5 the patient complained of cramping pain; at 6, pain was severe; at 8, pain had disappeared; at 9 and again at 10 it had returned.

(0.01 Gm.), was given subcutaneously. When the pressure reached the peak, a second dose of the relaxing drug was given to see if it would lessen the pressure caused by morphine. No depressor effect was produced on the morphine curve by atropine, histamine, phenobarbital sodium, alcohol or acetylsalicylic acid. A definite transitory decrease was noticed after small doses of epinephrine, but it made the patient uncomfortable.

The drug that produced complete disappearance of pressure and absolute relief of pain was amyl nitrite. A few whiffs of this drug almost at once brought the pressure down to zero, where it remained for a few minutes and slowly returned, after about fifteen minutes, to the level at which it had been after administration of the morphine. At the same time that the pressure fell, the patient was completely relieved of pain (fig. 6).

Glyceryl trinitrate produced a partial effect. It was about a third as effective as was amyl nitrite in depressing the curve that followed administration of morphine. However, it seemed of sufficient effect to cause relaxation of the spasm which produces the pain from which the patient ordinarily suffers. At present the patient mentioned in a preceding paragraph is being given one one-hundredth grain (0.0006 Gm.) of glyceryl trinitrate when she has an attack of pain. She claims relief in from five to ten minutes. However, the symptoms are subjective and it is very difficult to measure the amount of relief. After a year it has been found that although the various analgesics, very frequently morphine, do not relieve pain, glyceryl trinitrate always does relieve it. The patient has been under this treatment for two weeks. In that time she has improved objectively. She has gained weight and her general appearance is much better than before.

We have under observation at this time one other case. The patient is a man, aged 32 whose gallbladder was removed elsewhere in 1927. Since that time he has suffered attacks of very severe pain in the right upper abdominal quadrant at intervals of months, weeks or days; the attacks have lasted from fifteen minutes to eight hours. It was found very early that morphine would not relieve the pain, which was so severe that at times the patient would take 12 grains (0.77 Gm.) of sodium amytal and a pint (about one-half liter) of whisky. After administration of morphine, one-sixth grain (0.01 Gm.), as a test, cramping epigastric pain developed and gradually became more severe; later it became excruciating. An ampule of amyl nitrite was broken. After inhaling the fumes the man obtained immediate and complete relief. In ten minutes pain began to return in a mild form; one-hundredth grain (0.0006 Gm.) of glyceryl trinitrate brought relief after five minutes. In one hour pain returned; in five minutes it was again relieved by administration of glyceryl trinitrate; following this pain did not return.

SUMMARY

Administration of morphine produces a rise in pressure in the common bile ducts of patients whose gallbladders have been removed. This rise in pressure was accompanied by pain in one case. Periodic rises in pressure, with pain, have been demonstrated independent of the effect of morphine. Amyl nitrite and glyceryl trinitrate relieve the pain and pressure produced by morphine. Roentgenograms of the biliary tree can be made easily if a patient's gallbladder has been removed and drainage by T-tube is in progress. After proper preparation, a fluid that is opaque to roentgen rays can be injected through the T-tube; then the roentgenograms are made.

STOMATITIS DUE TO SENSITIZATION TO DENTAL PLATES

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CHICAGO

It is not generally recognized either by physicians or by dentists that an irritant stomatitis may result in a susceptible person from sensitization to materials in dental plates, particularly the newer synthetic substitutes for rubber plates. Three such cases have recently come to my attention:

CASE 1.—Mrs. T., aged 60, formerly a nurse, for years had worn full upper and lower plates made of vulcanite. They had never been entirely comfortable, apparently because of a poor fit, but the discomfort at most was never sufficient for her to do anything about it. Three years ago she had new plates made of a substance said to be hecolite. She wore them with complete comfort for three months. Then there developed burning tongue and shortly after that a peculiar salty taste accompanied by slight increase in salivation. The symptoms were always more severe at the end of the day, to improve over night when she did not wear the plates. But the condition became progressively worse, so that when she was seen in November 1935, in addition to the severe burning tongue and the salty taste she complained that the entire mouth was sore, including the gingivae, the buccal mucous membranes, the floor of the mouth and the palate. The lips felt dry and she suffered from nausea, frequent eructations and, as she expressed it, "a weak feeling in the stomach." At the end of the day there would be a thick glairy discharge from the mouth.

She had been assured by her dentist that there were no mechanical imperfections in the dentures to account for the symptoms, and repeated examinations by physicians also failed to reveal any cause for the symptoms.

On examination there was a diffuse inflammatory reaction of the mucosa of the entire oral cavity from the vermilion

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border of the lips to the pharynx. There was increased redness, very slight swelling and considerable serous exudate. The floor of the mouth and the buccal mucous membranes were involved to a lesser degree. The tongue was slightly enlarged. There were no ulcers or necrotic areas, and the vermilion surfaces of the lips were dry but not cracked.

The past history revealed that on one occasion in childhood the patient had had urticaria. To her knowledge there were no other indications of allergic diseases in herself or in other members of her family.

The sequence of symptoms beginning shortly after the wearing of a new denture suggested that the patient might be sensitive to something in the plates, especially since there were no other phenomena either medical or mechanical to account for the symptoms. A patch test was performed by strapping the plate to her arm, on the inner surface where the skin is thin. Forty-eight hours later there was an area of vesicular dermatitis on the site, which, as is shown in the illustration, was a mirror image of the plate in both size and shape. The same plate was then strapped to the skin of two other persons without producing a reaction. Within one week after she stopped wearing the plates there was a very striking improvement in both the stomatitis and the gastric symptoms. By the second week she was able to take fruit juices and spicy foods, which for the past two years she had been unable to tolerate. When some weeks later, just for a clinical test, she wore the plates again, there was a recurrence of all the symptoms within four hours. The patient continued to have slight burning of the tongue, much less however than with the original plates. Examination revealed a hypochromatic anemia, no free hydrochloric acid in the gastric contents, and slight atrophy of the tongue. A patch test with vulcanite was negative, with the original dentures it was again positive, and on wearing them there was again a recurrence of acute stomatitis.

CASE 2.—Mrs. M. C., aged 62, complained of burning tongue of about four years' duration. Her dental plates were also said to be made of hecolite, and she had worn them only a short time before the burning tongue began. The burning was intermittent in character and variable in severity. Usually she experienced the burning sensation only on the tip or sides of the tongue. Spicy foods aggravated the discomfort, and as with the first patient the symptoms were worse at the end of the day, and physicians and dentists had been unable to account for the symptoms. A patch test with the plate strapped to the arm produced a severe vesicular reaction within twenty-four hours. A change to vulcanite plates afforded decided relief from burning tongue within a relatively short period.

CASE 3.—A man, aged 50, had worn vulcanite plates with comfort for several years. The upper plate was accidentally broken and a triangular patch had to be inserted, just proximal to the central incisors. The patch was made apparently of one of the newer base materials that are used as a substitute for vulcanite. Within four days he felt burning of the tip of the tongue, and after a few days the area became red. Both symptoms and inflammation disappeared over night when the plate was not worn. The area of redness on the tongue was triangular and of the same size as the new patch on the plate, and it was situated where the tongue touched the patch—obviously a "contact" glossitis. His dentist could not find any mechanical fault to account for the symptoms, and because of the experience with the two previous cases it was thought that this was another case of sensitization to dental plates. A patch test on the arm made with scrapings from the insert in the plate, however, was negative. The negative test here may mean simply that in this patient the sensitization is confined to the tongue, a localized sensitization, or the inflammation of the tongue may be due to chemical irritation.

COMMENT

The cases were a new experience to me and when I casually mentioned it to several colleagues, medical and dental, it was apparent that the condition was new to them. In a fairly thorough search of the pertinent literature I was able to find an account of but one similar case, that of Lindsay, quoted by Lain.[1] Prinz and Greenbaum[2] also state that they have seen hypersensitiveness of the oral mucosa following the use of dental plates made of the newer base materials.

It is not unknown for sore mouth to develop after vulcanite plates have been worn, although it occurs relatively infrequently. "Rubber sore mouths" have been known ever since vulcanite has been used in plates,[2] and the subject has been fully discussed in dental literature. It is the consensus that the sore mouths are due probably to a combination of factors. The plate resting on the mucous membrane acts as a foreign body, which during mastication and speech mechanically irritates the mucous membrane, especially if it "rides the mucosa." There is as a result abnormality in the circulation of the mucous membranes and in its secretions. In addition the plates are not self cleansing, so that there may be an accumulation of food débris, and they are poor conductors of heat. Other factors, such as imperfect vulcanization causing porosity of the plate, and the possible poisonous action from chemicals used in the pigments, are also thought to be important in the development of sore mouths from dental plates. That dentists have been able to overcome most of these objections is evident from the fact that probably

Positive patch test from dental plate.

millions of people wear dental plates without discomfort. These and mechanical faults are usually sought in cases of sore mouth, but that the condition might be due to sensitization to the materials in the plates is not generally considered.

When the first patient was seen, a letter was addressed to the manufacturers of the denture material stating the facts and asking for information that might help to ferret out the irritating ingredient. They answered to the effect that there was nothing in the material that in any manner would cause chemical irritation, and they suggested that the symptoms were probably due to mechanical pressure. This, of course, does not account for the positive reaction to the patch test on the arm, which is made even more significant by the negative tests on two control patients. The newer base materials used as substitutes for vulcanite are made up essentially of cellulose treated with various chemicals and then combined with pigments, fillers and other substances. Others consist of phenol-resin compounds containing phenol, formaldehyde, ammonia, coloring matter and fillers. As Prosser White[3] has pointed out, coloring with chrome, polishing with lime

1. Lain, Everett: Chemical and Electrolytic Lesions of the Oral Cavity Produced by Metallic Dentures, Arch. Dermat. & Syph. **25**: 21 (Jan.) 1932.

2. Prinz, Hermann, and Greenbaum, S. S.: Diseases of the Mouth and Their Treatment, Philadelphia, Lea & Febiger, 1935, p. 215.

3. White, R. P.: The Dermatergoses, ed. 4, London, H. K. Lewis & Co., Ltd., 1934, p. 264.

and the numerous liquids used for the solution of cellulose can be ample sources of injury to the skin and, of course, to mucous membranes. The processes used in the manufacture of the various synthetic base plates are trade secrets, but judging from what is known about them it is quite likely that at some step in the process a compound is formed or an ingredient is used which might be irritating to the tissues in the mouth of a susceptible person. The cases herewith reported would seem to indicate so, for in none of them could the symptoms be accounted for on the basis of mechanical faults, infections or other medical factors, and, so far as could be determined, irritants such as dentifrices could also be eliminated as etiologic agents.

SUMMARY

Three cases of stomatitis followed the use of dental plates. In two of the cases there were strong reactions to patch tests on the skin made with the denture material. The dental plates, synthetic substitutes for vulcanite, are made by processes that are trade secrets, but sufficient is known of their composition to indicate that they can readily irritate susceptible tissues. The stomatitis in these cases is thought to be due to sensitization to the materials in the dental plates.

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PERINEAL TESTICLE

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Failure of the testicle to reach its proper destination in the scrotum is the commonest important anomaly of the spermatic tract. As a rule the improperly descended testicle is located at some point along the normal course of descent (abdominal, inguinal or high scrotal) but in some instances the organ is ectopic or aberrant. The ectopic gland may be (*a*) interstitial (lying anterior to the aponeurosis of the external oblique muscle), (*b*) femoral or crural (lying in Scarpa's triangle), (*c*) penile (overlying the pubic bone), (*d*) perineal and (*e*) transverse (fig. 1). In the last instance the two testes descend through the same inguinal canal. The present discussion concerns only perineal ectopia; three instances recently observed in children are reported.

ETIOLOGY

Incidence.—Perineal testicular ectopy is an unusual observation. Although the reported incidence of improperly descended testicle varies from 1.02 per cent in 108,000 men [1] to 3 per cent in 14,410 boys under 14 years of age,[2] Burdick and Coley [3] did not encounter a perineal testicle in 537 cases of cryptorchidism. It was not observed in 18,000 autopsies in males whose postmortem records I [4] studied for uropathy. Nor has a case of perineal testicle been seen in more than 36,000 admissions to the urologic service of Bellevue Hospital. On the other hand, Eccles [5] found five cases in 936 undescended testicles; Robertson [6] recently reported an operative case in a 3 months old boy. There are ninety-nine instances recorded in the literature to date. Curiously, in a moderate size general hospital I saw three cases during a period of twenty months.

Embryology.—The mechanism by which the testicle normally migrates from the high intra-abdominal position of early fetal life to the bottom of the scrotum is unknown. The oft repeated conception of downward

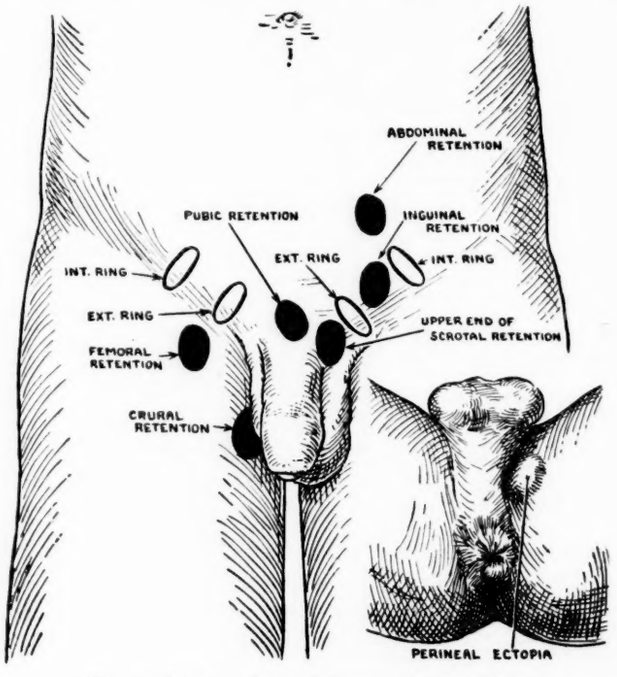

Fig. 1.—Sites of abnormal descent of the testicle.

traction of the testicle by the gubernaculum is still *sub judice* for, as Hunter [7] has shown, the testis of the newborn together with the fascial coverings may be lifted out of the scrotum without tearing anything but a little superficial connective tissue. Lockwood's [8] theory of

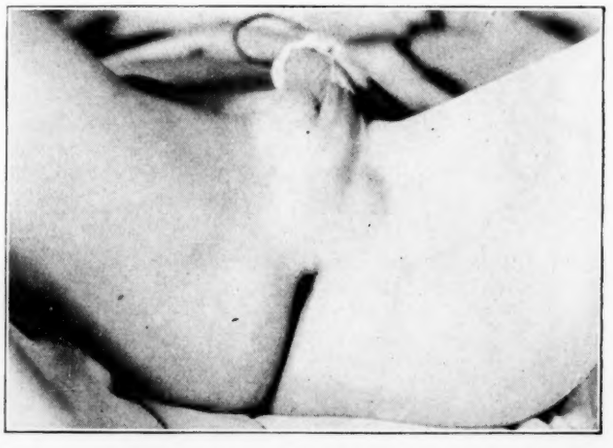

Fig. 2 (case 1).—Left perineal testicle in 11 year old boy. Indwelling catheter in urethra following transurethral resection of congenitally hypertrophic verumontanum.

a multitailed gubernaculum, the tails of which pass from the testicle to the bottom of the scrotum, the pubis (penile), the spine of the ischium (perineal) and Scarpa's triangle (femoral or crural), has been adduced by some to explain testicular ectopy; i. e., the testicle goes in the direction of the strongest pull. Suggestively

From the Department of Urology, Mountainside Hospital, Montclair, N. J.

1. Marshall, E.: Edinburgh M. & S. J. **30:** 172, 1828.
2. Coley, W. B.: Ann. Surg. **48:** 321, 1908.
3. Burdick, C. G., and Coley, B. L.: Ann. Surg. **84:** 867 (Dec.) 1926.
4. Campbell, M. F.: Pediatric Urology, to be published.
5. Eccles, M.: Brit. M. J. **1:** 570, 1902; **2:** 1314, 1902.
6. Robertson, Hugn: Ectopia Testis Perinei, J. A. M. A. **95:** 191 (July 19) 1930.
7. Hunter, R. H.: Brit. J. Surg. **14:** 125 (July) 1926.
8. Lockwood, H.: Brit. M. J. **1:** 444, 1887.

commending this theory was the observation in my two operative cases that the strong gubernaculum passed from the lower pole of the testicle to the spine of the ischium and firmly withheld the organ in the perineum. Yet Sonneland[9] discards Lockwood's notion and believes that, once the testicle has descended through the external inguinal ring, the action of the gubernaculum is no more than passive. If the gubernaculum is inadequate or breaks at this point, the testicle descends along the line of least resistance and becomes ectopic. The anomalous descent occurs between the same fascial planes (superficial or Camper's and deep or Scarpa's) that guide urinary extravasation. Some writers believe that a tight scrotal aperture above (the so-called third inguinal ring[10]) may deflect the descending testicle. This observation was striking in both the boys on whom I operated.

PATHOLOGY

The perineal testicle is subject to the same unfavorable factors as are organs in inguinal or other forms of maldescent. If the anomalous condition is permitted to persist, atrophy and loss of fertility of the gland are certain. The organ is subjected to ill borne trauma and, according to Dean,[11] the improperly descended testicle is 200 times more likely to become the site of a malignant growth than is a normally descended gland.

SYMPTOMS AND DIAGNOSIS

Presence of the testicle in the perineum and its corresponding absence from its normal scrotal position is both the commonest presenting symptom and the diagnostic criterion. The organ may be relatively insensitive (when greatly atrophied) or it may be the site of intermittent or constant dull or acute pain. Epididymitis in a perineal testicle has been reported.[12] By palpation the relative degree of testicular atrophy can be determined by comparison with the normal mate. In any patient with cryptorchidism the perineum should be examined.

Sometimes, as illustrated by cases 1 and 3, the testicular anomaly may be but one of a number of congenital developmental errors. Moreover, it is observed that in about 35 per cent of cases of genital anomaly the upper urinary tract also is anomalous (e. g., case 1).

TREATMENT

Treatment is necessarily surgical. There is no preventive treatment. For obvious reasons hormone therapy (pregnancy urine extracts such as antuitrin-S and follutein), which is often so valuable in inguinal and abdominal testicular maldescent, is of no help in perineal or any other form of testicular ectopia. The spermatic cord is long enough, but the gland has descended into the wrong channel and can be properly placed only by surgical methods.

Time for Operation.—Unless the ectopic gland is producing symptoms, operation should be withheld until after the third birthday. It is advisable, however, to transplant the testicle to its normal scrotal location soon thereafter, and in all events before the boy starts riding a bicycle or in active play runs the risk of a straddle injury.

Operation.—Through an incision from 3 to 4 cm. long, the external inguinal ring and the upper portion of the ectopic spermatic cord are exposed. The incision begins just above the level of the external ring and extends downward in the scrotofemoral fold toward the ectopic gland. Between the superficial and the deep perineal fascial layers the testicle will often be found firmly anchored by its gubernaculum, perhaps most frequently to the spine of the ischium. The gubernaculum is now divided so that a generous segment remains for suture to the depth of the new scrotal pocket. The cord, which will be found of ample length, is mobilized to the external inguinal ring and is examined for a hernial sac. Yet congenital hernia is not common in perineal testis. The tunica vaginalis is now everted behind the testicle. This prevents traumatic (surgical) hydrocele, which is almost certain to follow if the precautionary eversion is not performed. An adequate pocket is made in the scrotum to receive the testicle. The pocket is turned inside out and to its depths the gubernaculum is stitched with fine chromic gut. Due care must be observed that in transplanting the testicle to the scrotum the cord is free of torsion. The testicle having been properly placed, it is well to close the fascial ring of the upper part of the scrotum with two or three fine chromic sutures to keep the testicle down in the scrotum. In other words, the so-called third inguinal ring is reformed. The wound is now closed without drainage.

In my two operative cases I anchored the gubernaculum with a transfixion ligature of unabsorbable suture, which was then passed out through the bottom of the scrotum. This suture was tied to a small rubber band, to which in turn was tied a suture passed through the skin of the lower inner thigh. These sutures were tied to the interposed rubber band under sufficient tension to cause mild traction to be exerted on the testicle, a maneuver adopted from Cabot's technic in the correction of undescended testicle. In from three to six days the traction suture pulls out, but during this time the testis has become well adherent to the bottom of the scrotum and the cord has been kept at full length.

Should hernia coexist, herniotomy also is performed.

REPORT OF CASES

CASE 1.—H. S., aged 11 years, was referred by Dr. Henry Larson of Morristown, N. J., Oct. 6, 1934, because of persistent pyuria, repeated gastro-intestinal disturbances, and failure to gain. A thorough urologic examination at Mountainside Hospital revealed advanced infected hydronephrosis (Bacillus coli and Staphylococcus aureus) of the lower half of a reduplicated left kidney; a stricture at the vesical junction of the ureter to the diseased segment was the important accessory cause of the renal pathologic condition. Other discoveries of urologic importance included a congenital stricture (7 F.) of the urethra at the penoscrotal angle, congenital hypertrophy of the verumontanum, spina bifida occulta, six lumbar vertebrae, a residual urine which varied between 5 and 7 ounces (150 and 210 cc.), and a left perineal testicle. The gland felt normal and was situated just to the left of the midperineum (fig. 2). Other physical appearances were normal.

The boy also suffered a curious hematologic anomaly which made it necessary to type fourteen members of his blood group (Moss III) before one was found whose cross agglutination test was negative after thirty minutes. Yet when transfusion was done an almost fatal reaction occurred.

Left ureteroheminephrectomy was performed October 12. In three and a half weeks the boy went home, to return November 13, at which time the left perineal testicle was put in its normal position in the scrotum and the infravesical obstructions were eradicated.

With the patient in the lithotomy position and under nitrous oxide-oxygen anesthesia, the operation described under surgical treatment was carried out. The ectopic spermatic cord was mobilized from the external inguinal ring downward and finally

9. Sonneland, S. G.: Ann. Surg. **80**: 716 (Nov.) 1924.
10. McGregor, A. L.: Surg., Gynec. & Obst. **49**: 273 (Sept.) 1929.
11. Dean, A. L., Jr.: Personal communication to the author.
12. Franz, F. W.: Northwest Med. **34**: 309 (Aug.) 1935.

the testicle was separated from its perineal attachment of the gubernaculum to the spine of the ischium. It was noted that the gubernaculum was unusually well developed and extremely tense. The tunica vaginalis was now incised and everted behind the testicle, where it was held by a fine mattress suture. The testicular mesentery was extremely long and permitted the epididymis to hang freely as a wormlike structure. The operation was then completed according to the previously described technic. The urethra was dilated to 18 F. With my miniature resectoscope and the high tension cutting current the greatly hypertrophied verumontanum was subtotally resected. There was mild bleeding; indwelling catheter drainage (12 F.) was established. Immediate convalescence was uneventful, but on the third day and soon following the removal of the indwelling catheter the patient had a chill, the temperature rose to 105.4 F. and the pulse rate increased from 90 to 154 beats per minute. The catheter was reinserted for two days; the acute reaction subsided within twelve hours. In two days the temperature was normal and on the sixth day the traction suture cut through and released the testicle. The boy returned home eight days after the operation.

Postoperatively the urethra has been periodically dilated and the urine has been sterilized with large doses of methenamine (from 60 to 75 grains [3.8 to 4.8 Gm.] per day) and of ammonium chloride. Of the latter, 200 grains (13 Gm.) a day was necessary in order to obtain the desired urinary acidity of p_H 5.5. The urine has been sterile for more than a year and there has been no residual urine. The testicle previously ectopic is now normal in position and to palpation.

This case admirably illustrates the startling number of urogenital anomalies with which an individual may be born. It also indicates how, by multiple step procedures and with the application of modern methods of diagnosis and surgical treatment, many of these congenital handicaps (some of which are potentially fatal) can be eradicated. It is of further interest that during the six months following ureteroheminephrectomy the boy gained 24 pounds (11 Kg.). Repeated gastro-intestinal disturbances and failure to gain had been important symptoms in the past history and obviously resulted from renal toxemia.

CASE 2.—J. B., aged 7 months, admitted to the urologic department of Mountainside Hospital in January 1934, had a perineal testicle on the left side. The boy's history and physical examination were otherwise negative. The ectopic gland was of normal size and was situated in the posterior perineum slightly to the left of the midline. Because of his tender age, operation was deferred. The patient was again seen Sept. 23, 1935, at the age of 24 months. Conditions were the same as on the first examination. A questionable left hernial impulse was obtained.

September 26 the perineal testicle was replaced in the scrotum in a manner identical with that previously described. No hernia was found. The traction suture pulled out on the third day. The boy left the hospital one week after operation and when seen four months later presented a most satisfactory surgical end result.

CASE 3.—S. T., aged 14 years, was seen in the urologic department of Mountainside Hospital, Aug. 29, 1935. The right testicle was undescended at the external inguinal ring, where there was a moderate hernial impulse. The left testicle was found in the midperineum and when palpated appeared to be of normal size. Operation was advised, a Torek procedure to be carried out on the right side and the previously described operation for perineal testicle on the left. Because of parental objection this has not yet been accomplished.

SUMMARY

Perineal testicle is an unusual genital anomaly. The embryologic etiology is unknown. Diagnosis is made by inspection and is confirmed by palpation. The treatment is surgical and consists of placing the ectopic organ in a newly made pocket in the scrotum. Unless this is done the ectopic organ is abnormally subjected to trauma; atrophy and isolateral sterility are almost certain. Endocrine therapy is ineffectual in correcting this variety of maldescent. There should be neither surgical morbidity nor surgical mortality.

140 East Fifty-Fourth Street.

THE PRESENT STATUS OF OUR KNOWLEDGE OF HEREDITY AND CANCER

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BAR HARBOR, MAINE

During the past thirty years, evidence derived from biologic experimentation in the laboratory has yielded considerable information concerning the nature of the constitutional or hereditary factors which predispose certain animals to cancer and which make others unlikely to develop it. As long ago as 1907-1910, Tyzzer, J. A. Murray and Bashford had pointed out that, in mice, the progeny of females which developed spontaneously cancer of the breast were more apt to form this type of neoplasm than were animals not so descended. Slye in a long series of papers demonstrated, as did Loeb and Lathrop, that different families and strains of mice showed, in each case, a more or less characteristic degree of cancer function. None of these investigators had available for experimentation strains in which genetic homogeneity had been attained. As a result, the genetic variables that were present prevented an exact test of the nature of the process of transmission from one generation to another of the tendency to form cancer.

The key as to how to obtain strains that were genetically homogenous first became known to geneticists by the work of Johannsen and of Jennings in 1909. It was not, however, until another decade had passed that the production of such homogenous strains became generally recognized as an essential step before the genetics of any such a phenomenon as cancer could be investigated. The process by which genetic uniformity is produced is one of rigid inbreeding of own brother to sister or of progeny to parents. King's well known work with inbred selected strains of rats did much to show that the process could be outstandingly successful and proved the incorrectness of such assertions as that of Slye to the effect that "continued inbreeding eliminates any strain."

Beginning in 1909 I had selected for intensive inbreeding the descendants of a single pair of mice the color of which was dilute brown. This strain has been continued since that date. As time passed other unrelated inbred strains have been developed. In some of these the incidence of cancer of the breast runs as high as from 85 to 100 per cent in breeding females 14 months of age or older. In others cancer of the breast occurs very rarely, perhaps in 0.1 per cent or less. Other types of neoplasm are also obtained in characteristic amount according to the particular strain used.

There are three levels at which the genetics of cancer can be investigated. One of these deals with the genetic behavior of animals in relation to transplants of various tumors which originated spontaneously either within a given strain or in some unrelated strain.

The genetics of susceptibility or nonsusceptibility to transplants of various tumors was successfully worked

From the Roscoe B. Jackson Memorial Laboratory.

out by Bittner, Cloudman, Strong and myself during the period 1914-1936. It has been reviewed by Haldane and by Bittner.

Whether a given animal will grow a certain tumor on transplantation depends on the degree of biologic similarity between the host and the tissue of the tumor used for transplantation. The degree of biologic resemblance is chiefly determined by mendelian genes. The number of genes involved varies in each case, being as low as one in some cases investigated and as high as twelve or fifteen in others. This general conclusion is based on the genetic analysis of more than thirty different spontaneous tumors and on more than 25,000 individual transplantations.

By 1928-1929 there were on hand a sufficient number of inbred strains of mice to make the beginning of work on the genetics of spontaneous tumors seem desirable. Strains high in cancer incidence were crossed with low cancer strains in various ways and the hybrids of different generations were observed for cancer incidence. All animals were examined after death and all suspicious nodules were sectioned and diagnosed.

With the coming to maturity of females that were first generation hybrids between cancer and "non-cancer" strains, a test was provided for Slye's widely publicized hypothesis that the incidence of all spontaneous cancer is due to a single mendelian recessive hereditary factor. The presence of a large number of cases of cancer in the first generation hybrids has definitely disproved this theory, which even on Slye's own data I had shown (1928) to be of extremely doubtful validity.

At the same time (1933-1935) results have been published which establish certain general principles for future guidance. Without detailed consideration of the various publications to which reference will be made, these principles and conclusions may be very briefly summarized as follows:

1. That the genetic constitution of an animal is of prime importance in determining the likelihood of its having cancer of the breast is shown by outcrosses between high and low cancer strains.

If a strain in which the incidence of breast cancer among virgin females is high (approximately 50 per cent) is crossed with a low cancer strain, the amount of breast cancer appearing among virgin females of the first hybrid generation is largely dependent on the strain from which the female ancestor is derived.

Thus if a "high" strain female is crossed with a "low" strain male the incidence of breast cancer in the virgin female hybrids is approximately 39 per cent.

If, on the other hand, a "low" strain female is crossed with a "high" strain male the incidence of breast cancer is only 6 per cent.

This difference holds good for the second hybrid generations as well as for the first, in a large number of animals (over 1,200).

This type of inheritance is nonmendelian and is unique among animals. It follows the maternal line and definitely establishes the existence of genetic influences outside the chromosomes.

2. Studies of a preliminary nature have shown no such unusual behavior of genetic factors underlying the incidence of such tumors as lymphosarcomas. The genetic influences in this case seem to be equally derived from either the male or the female line. This is characteristic of the normal type of mendelian inheritance, which depends on the chromosomes. The distinction between cancer of the breast and such types as lymphosarcomas thus seems fundamental. As far as the present evidence is concerned there seem to be many genetic factors involved in the spontaneous incidence of sarcomas of various types.

3. Blockage of the nipples on one side of the body resulting in no drainage during lactation seems to make the blocked side a more frequent site of breast cancer among females derived from a high cancer stock. It fails entirely to produce cancer in females derived from a low cancer stock. This is a clear proof of the relative rôles of constitution on the one hand and irritation due to blockage on the other. The former is basic (Green and Fekete).

4. There is some relationship between the amount and function of mammary tissue and its tendency to form a cancer in those inbred strains of mice which are high in cancer incidence. Thus virginity delays the appearance of cancer of the breast and also actually reduces the amount of it appreciably (W. S. Murray).

5. The presence of ovarian secretion is a factor in influencing the amount of mammary development and consequently affects its ability to act as the site of cancerous changes.

6. For this purpose it is not necessary to derive the ovarian secretion from a high cancer strain individual. Thus ovaries from a low cancer strain transplanted in castrated animals of a high cancer tendency, or even injections of theelin in such animals, will allow cancer of the breast to develop in some cases (J. M. Murray, Lacassagne, Little, unpublished data).

7. Absence of testicular secretion caused by castration after 4 weeks of age is not sufficient to allow males that are brothers of females in a high cancer stock to develop cancer of the breast. On the other hand, when such castrated males receive and maintain transplanted ovaries (W. S. Murray) or injections of theelin (Lacassagne) they may develop cancer of the breast.

8. The technic of keeping the genetic constitution constant and varying the ovarian and mammary functions has given sufficient information to make it possible to recognize that the degree and extent of those functions is a factor of the internal environment of the individual which may importantly affect the incidence of breast cancer.

9. The technic of keeping ovarian and mammary function constant and varying the genetic factors has shown that hereditary transmission of constitutional influences plays a basic rôle in the incidence of cancer of the breast.

It may be pointed out in conclusion that the accepted method of making human matings, viz., by uncontrolled outcrossing combined with the inadequate records and small numbers of progeny which commonly are encountered in human families, militates against the practical use of controlled heredity as a means of reducing the incidence of cancer in man. This, however, does not prevent the genetic approach to the problem in the laboratory and the use of controlled homogeneous inbred strains of mice from being extremely favorable material for pure scientific research in the nature and cause of cancer.

Signers of the Declaration of Independence.—Five of the fifty-six signers of the Declaration of Independence and twenty-three members of the Provincial Congress of Massachusetts in 1774-1775 were medical men.—Patterson, R. U.: Some Important Contributions to Medical Science by Military Surgeons, *J. Oklahoma M. A.* **29**:157 (May) 1936.

Clinical Notes, Suggestions and New Instruments

A CASE OF CONTACT DERMATITIS PRODUCED AT A DISTANCE BY THE SENSITIZING AGENT

JOSEPH B. BIEDERMAN, M.D., CINCINNATI

In the classification of skin diseases, contact dermatitis or dermatitis venenata appears as a clinical entity, separate from the more inclusive term eczema. The chief reason advanced for this separation is that in contact dermatitis it is necessary to have actual physical contact between the causative agent and that portion of the skin involved. The case herewith presented demonstrates that contact dermatitis or dermatitis venenata may be produced by a sensitizing agent acting at a distance.

C. M., a man, aged 29, a truck driver, complained of a dermatitis present on the extensor surfaces of both hands and both feet. This had been present for the past six months. The patient stated that one and one-half years before he had had a similar ailment, which lasted for three months and disappeared. He had been driving a truck for six years, but only for the past one and a half years had he noted an eruption. At that time he took a trip into the country and two weeks later the eruption on both hands and feet disappeared. It had been present for ten weeks previously. One year before admission he again began to drive a truck and six months later the eruption reappeared on the dorsum of the hands, where it remained for three months and then involved the dorsum of both feet. He complained of itching and burning of the areas involved, which were worse while he was at work or after he worked on his own automobile. Occasionally the entire body would itch and burn, but most of the symptoms were limited to the hands and feet. His past history was negative for any allergic manifestations. His family history revealed that his mother had had hay fever and his father asthma.

Physical examination was not remarkable except for the skin lesions present on the dorsum of both hands and both feet. The eruption was characterized by scales, fissures and marked reddening. There were also some areas oozing a thin watery material.

The urine and blood count were within normal limits, and the blood Wassermann test was negative. Extensive skin tests with the intracutaneous method were all negative. The usual common materials used in the patch tests were also negative.

He was then told to bring a sample of everything he handled while at work. Everything tested was negative. He mentioned that he was in the habit of washing his hands with gasoline when they were very dirty. He was told to bring a sample for the purpose of testing of each kind of gasoline he used. He brought Ethyl, X-70 and Renown gasolines. Each of these was placed in a separate 1 ounce glass container and the flexor surface of his forearm was placed over the openings of these bottles. Fifteen minutes later the Ethyl caused itching and burning, and the area of skin covering the open end of the bottle was reddened. Forty-five minutes later X-70 and Renown both showed the same effect. All the involved areas also showed the presence of blisters about six hours after contact with the gasoline. The itching and eruption caused by X-70 and Renown practically disappeared in twenty-four hours. That caused by Ethyl persisted for forty-eight hours. My arm, used as a control, was entirely normal. This reaction could very well explain the eruption on the dorsum of both hands, but could this explain the involvement of both feet? So far as the patient knew, his feet had not been in contact with gasoline. He was advised to discontinue work, and again his skin cleared. When he resumed his former work the lesions reappeared after an interval of three months.

The possibility presented itself that the dermatitis on the back of the feet might be due to a localization there of the excess gasoline absorbed elsewhere.

The following experiment was then performed: Each forearm was exposed daily for forty-five minutes to the vapors given off from the three brands of gasoline he used, and the results are noted in the accompanying table. The first day, fifteen minutes after the application of the ethyl gasoline, an itching and redness was noted on the patient's arm. Forty-five minutes after application all three areas itched to such an extent that the patient asked to have the experiment stopped. My forearms used as a control were not involved. Five hours later the redness was followed in another hour by blisters. The lesions caused by X-70 and Renown gasolines practically disappeared after twenty-four hours, while the lesions due to Ethyl gasoline lasted for forty-eight hours. The second day the same procedure was carried out on the other forearm, with practically the same results. This experiment was performed daily with the same results but using different clear spots on alternate arms until the eighth day, when an eruption appeared in the popliteal areas and he complained of "feeling miserable over his entire body" about the same time. He also complained simultaneously of a feeling of fulness in the joints. Nevertheless he asked to have the experiment continued. On the ninth, tenth, eleventh and twelfth days the same procedure was followed, except that the gasoline was applied twice a day instead of once. Until this time I would place the gasoline on alternate arms. When I alternated thus the lesions would disappear (except those caused by Ethyl) when I was again ready to use the same arm. On the twelfth day, however, the healed areas on the two arms erupted simultaneously with those on both legs. One day later, although no more gasoline vapors were contacted, the eruption spread over the entire body. The popliteal areas, the flexor surfaces of the forearms, and the axillae were most extensively involved. Fifteen minutes before the generalized eruption occurred, the patient stated that he felt as though needles were pricking his bones. Within two months the lesions had healed. He was told to avoid contact with gasoline and has been free from symptoms except on two different occasions when he has had definite exposure to gasoline.

Experiments with Three Brands of Gasoline Used by Patient

Applied 45 Minutes Daily for 8 Days, Then Twice Daily	Time Observed	First Days' Observations	Second Through Seventh Days	Eighth Day	Ninth Through Eleventh Days	Twelfth Day	Thirteenth Day
Renown gasoline	15 minutes	Nothing remarkable	Practically the same as first day	Practically the same as the first day except that an eruption appeared in the popliteal areas; general symptoms also developed	Practically the same as eighth day	Eruption over all of healed areas as well as over both legs	Eruption spread over the entire body and generalized symptoms complained of
	45 minutes	Redness and itching					
	5 hours	Redness and itching lessened					
	6 hours	Blisters appeared					
	24 hours	Skin practically clear					
	48 hours	Skin clear					
X-70 gasoline	15 minutes	Nothing remarkable	Practically the same as first day	Practically the same as the first day except that an eruption appeared in the popliteal areas; general symptoms also developed	Practically the same as eighth day	Eruption over all of healed areas as well as over both legs	Eruption spread over the entire body and generalized symptoms complained of
	45 minutes	Redness and itching					
	5 hours	Redness and itching lessened					
	6 hours	Blisters appeared					
	24 hours	Skin practically clear					
	48 hours	Skin clear					
Ethyl gasoline	15 minutes	Itching and redness	Practically the same as first day	Practically the same as the first day except that an eruption appeared in the popliteal areas; general symptoms also developed	Practically the same as eighth day	Eruption over all of healed areas as well as over both legs	Eruption spread over the entire body and generalized symptoms complained of
	45 minutes	Intense itching and redness					
	5 hours	Blisters present					
	6 hours	Blisters and redness					
	24 hours	Blisters and redness					
	48 hours	Practically clear					

From the Allergy Clinic, Cincinnati General Hospital, University of Cincinnati Medical College.

This case is reported to demonstrate that it is possible to have a so-called contact dermatitis caused by the responsible agent acting at a distance from the skin area involved. These studies suggest that after repeated exposure to a sensitizing agent the latter can be absorbed and affect other areas of the skin not in direct contact with the offending agent, whereas a smaller quantity may cause only a local lesion.

Doctors Building.

TRAUMATIC DELTOID PARALYSIS TREATED BY MUSCLE TRANSPLANTATION

WILLIAM DONALD DAVIDSON, M.D., EVANSVILLE, IND.

Flaccid paralysis of the deltoid muscle may result from poliomyelitis, obstetric paralysis or traumatic injury of the circumflex (axillary) nerve. Various operative procedures have been proposed to relieve this severe lesion. Of these the transplantation of the origin of the short head of the biceps from the coracoid process, and the origin of the long head of the triceps from the inferior margin of the glenoid cavity, to the tip of the acromion, as proposed by Dr. Frank Ober,[1] has been the most successful.

The operation was first used to relieve deltoid paralysis resulting from infantile paralysis, but Dr. Ober has since extended its use to those cases resulting from obstetric paralysis. This report is to present a case of deltoid paralysis, caused by a traumatic lesion of the circumflex nerve, in which this operation was successfully used.

ANATOMY

The circumflex nerve arises from the posterior cord of the brachial plexus and consists of fibers from the dorsal divisions of the fifth and sixth cervical nerves. It passes downward and outward from behind the third portion of the axillary artery and over the outer border of the subscapularis muscle to enter the quadrilateral space, where it lies beneath the posterior circumflex artery and vein. It then turns about the posterior and external surface of the surgical neck of the humerus to end within the deltoid muscle. The nerve consists of two main bundles, the larger medial funiculus supplying the teres minor and a part of the deltoid, after which it passes under the deltoid and around the lower part of the posterior border to supply the skin over the long head of the triceps and the lower two thirds of the posterior part of the deltoid. The lateral branch supplies the remainder of the deltoid and gives off an articular branch to the shoulder joint.

This exposed position of the circumflex nerve makes it particularly liable to injury. It may be easily torn or compressed in fractures of the surgical neck of the humerus or in dislocations of the shoulder joint, or it may be contused by blows on the shoulder. If paralysis of the circumflex nerve results, loss of motor power to the deltoid and teres minor muscles results in an inability to abduct the arm. Elevation of the arm to a degree less than a right angle may be accomplished by the supraspinatus muscle.[2] There is also a loss of sensation over the cutaneous distribution of the nerve, involving the skin over the long head of the triceps and the lower posterior part of the deltoid.

REPORT OF CASE

M. K. K., a student nurse, aged 20 years, has always been very athletic. On the first day of her annual vacation, Aug. 3, 1935, she was in swimming. A diver struck her forcefully on the left shoulder. On the following day the entire left shoulder region was so painful that motion was impossible. Motion gradually came back, and by the time she returned to duty she could abduct the left arm to 80 degrees with the elbow flexed to a right angle. She continued on duty until September 30, when her room-mate noticed that the left shoulder region was markedly flattened. She was seen on the following day and stated that there was a continuous dull ache in the left shoulder and that she did not possess the full use of the arm. Physical examination at that time showed a marked atrophy of the left deltoid, in contrast to the excellent development of the neighboring muscles. This atrophy caused undue prominence of the acromion and coracoid process. The capsule of the shoulder joint was relaxed three-fourths inch. All motions of the arm except abduction and forward raising were normal. With the elbow extended, she was able to abduct the arm 30 degrees. When the elbow was flexed at this point, the long head of the biceps aided the supraspinatus, and abduction was possible to 80 degrees. Sensory examination showed complete anesthesia over the complete cutaneous distribution of the circumflex nerve. Electrical stimulation showed an absent response of the deltoid muscle to the galvanic current. Neurosurgical consultation was obtained and the diagnosis of a traumatic lesion of the circumflex nerve confirmed. The consultant did not recommend exploration of the nerve. The left arm was placed on a platform splint, holding the shoulder in 90 degrees abduction and 10 degrees forward of the coronal plane. Daily sinusoidal current and diathermy treatments, together with massage and exercises, were begun.

The possibility of muscle transplantation had been discussed with the patient. Toward the latter part of November she requested operation, saying that the shoulder ached continually and that she was afraid that she would not be able to resume training. December 2, four months after the injury, operation was performed. The short head of the biceps and the long head of the triceps were freed subperiosteally from their origins and transplanted into a shark mouth incision osteotomized in the tip of the acromion. At the time of operation, the deltoid and teres minor were found to be completely flaccid. The transplanted muscles were exceptionally large and of excellent quality. Special care was taken in closing the deep fascia. At the conclusion of the operation, the humeral head was quite firmly held in the glenoid cavity. The arm was replaced on the platform splint. On the third postoperative day, the patient stated that the dull dragging sensation in the shoulder had disappeared. Muscle reeducation was begun on the fourteenth postoperative day, at which time the transplants could be felt to contract. The following day, with the arm gently supported, she could raise the arm 10 degrees from the splint, while on the eighteenth postoperative day she could raise it above her head. At the end of six weeks she could raise the arm from her side to above her head or abduct it through the same range. Abduction was possible using each transplant separately, as well as by their combined action.

She returned to light duty at the end of eight weeks, wearing the splint during class hours and at night, and returned to full floor duty at the end of twelve weeks. At the time of this report, it has been seven months from the time of the original injury and fourteen weeks since operation. She has full functional use of the left arm and is performing regular nursing duties in a satisfactory manner. Paralysis of the circumflex nerve is still complete, as evidenced by the undiminished area of skin anesthesia and the absence of reaction of the deltoid to electrical stimulation. On being shown a recent report of a case in which spontaneous recovery of a paralyzed circumflex nerve began after seven months,[3] she remarked that she still was quite satisfied to have had the operation, since she could do all her work and did not have to wear a splint.

CONCLUSION

This case is reported as evidence that transplantation of the short head of the biceps and the long head of the triceps to the tip of the acromion is of value when deltoid paralysis results from trauma to the circumflex nerve, as well as in cases resulting from poliomyelitis or obstetric paralysis. The sound mechanical principle underlying this type of operation, as evidenced by ability to abduct the arm by either transplant acting separately, indicates that better function in the other types of deltoid paralysis should be obtained by this operation than by other types of muscle transplants. It is felt that, since a traumatic lesion of the circumflex nerve gives a prolonged disability and an uncertain prognosis, this procedure may be done advantageously in those cases in which time is an important factor and that it offers more hope than exploration of the nerve. If spontaneous recovery should occur, the transplants will prevent undue strain on the deltoid and check any tendency of the capsule to relax.

530 Main Street.

1. Ober, F. R.: An Operation to Relieve Paralysis of the Deltoid Muscle, J. A. M. A. **99**: 2182 (Dec. 24) 1932.
2. Codman, E. A.: The Shoulder, Boston, Thomas Todd Company, 1934, p. 393.
3. Hirsch, Sidney: Paralysis of the Axillary (Circumflex) Nerve with Spontaneous Recovery After Seven Months, J. A. M. A. **106**: 705 (Feb. 29) 1936.

RECURRENCE OF PAROXYSMAL AURICULAR FIBRILLATION AFTER PERMANENT RELIEF OF HYPERTHYROIDISM BY SUBTOTAL THYROIDECTOMY

ERNST P. BOAS, M.D., NEW YORK

This report concerns a patient with hyperthyroidism with established auricular fibrillation before operation, in whom sinus rhythm was restored following the postoperative administration of quinidine. Nineteen months after her thyroidectomy she was operated on for carcinoma of the colon. This operation was performed in three stages. Immediately after two of these operations transient auricular fibrillation developed, which subsided spontaneously after about twelve hours on each occasion. Since that time a year and a half has elapsed and the rhythm has remained regular.

A woman, aged 50, seen June 14, 1932, had had the menopause three years previously. She had been well until about a year previously, when she began to complain of increasing weakness and nervousness. She became excited very readily and noted palpitation and dyspnea on exertion. Two weeks previously during a meal, she suddenly was unable to move her right hand and her speech was altered. These symptoms lasted only a few moments. The following day she vomited. These symptoms did not recur. She had lost 7 pounds (3,175 Gm.) during the previous two months.

On examination the patient was well nourished, weighing 157 pounds (71 Kg.). There was marked tremor of the hands. There were no paralyses and all the reflexes were normal and exaggerated. The eyes were not prominent, and there were no abnormal eye signs. The thyroid isthmus was palpable but did not appear enlarged. There was no substernal thyroid. The lungs were clear. Fluoroscopy revealed moderate enlargement of the left ventricle. The first heart sound was of good quality. There were no murmurs or accentuations. The rhythm of the heart was absolutely irregular, the rate being about 120. The blood pressure was 160 systolic and 80 diastolic. The electrocardiogram revealed left axis deviation, auricular fibrillation and occasional ventricular extrasystoles. The basal metabolic rate was plus 38 per cent.

She was prepared for operation with aqueous solution of iodine and, June 27, subtotal thyroidectomy was performed by Dr. Harold Neuhof. A rather large right lobe, containing a cyst, and a small left lobe were found. The auricular fibrillation persisted and five days after operation she received quinidine sulfate. After 24 grains (1.5 Gm.) of the drug had been administered, sinus rhythm was restored. The heart rate was 64. July 12, auricular fibrillation recurred but was quickly controlled with further dosage of quinidine. Following this the heart remained regular. She lost her nervousness, gained 7 pounds and was free from symptoms. November 3 her basal metabolic rate was minus 9 per cent. Her pulse rate was 54, the rhythm was regular and the blood pressure was 160 systolic, 80 diastolic. She was seen again, Feb. 16, 1934. During the previous six months she had had occasional sticking cramps in the left lower quadrant. Five days previously these cramps became very severe and during this period there had been no bowel movement. A small mass was felt in the left lower quadrant. Roentgen examination of the colon revealed a marked constriction at the junction of the sigmoid and descending colon. There was no recurrence of the hyperthyroidism or of auricular fibrillation. Dr. Leon Ginsburg, performed a Mikulicz operation for carcinoma of the descending colon in three stages. February 17 a cecostomy for intestinal obstruction was performed. This was uneventful. March 5 the second stage of the operation was performed under spinal anesthesia. The operation lasted one hour and forty minutes. At the end of the operation the rhythm of the heart was absolutely irregular and its rate was 136. The irregularity persisted for thirteen hours, when sinus rhythm was reestablished spontaneously. During this period the temperature was normal. There was no recurrence of the irregularity until June 11, when the patient was again operated on under spinal anesthesia for extraperitoneal closure of the colon. Again the operation was followed by a short period of auricular fibrillation, which disappeared spontaneously. The rhythm has remained regular ever since and there have been no cardiovascular symptoms.

Auricular fibrillation is rarely provoked by anesthesia and operation except in patients with hyperthyroidism. Kurtz and his associates[1] encountered it only once in 113 nonthyroid operations during which the patients were studied electrocardiographically, and that was in a patient with heart disease. Commonly patients with hyperthyroidism with normal cardiac rhythm before operation develop auricular fibrillation during the first two or three days following operation. The immediate increase of basal metabolism following operation has been held responsible for this phenomenon.[2]

Following subtotal thyroidectomy there is a spontaneous reversal to normal sinus rhythm in about 50 per cent of patients with hyperthyroidism and auricular fibrillation, and if quinidine sulfate is given to the remainder only 10 per cent of the whole group maintain their abnormal rhythm.[3] The refractory cases are those with an additional type of heart disease or those in which operation has been incomplete. The irregularity persists, particularly in patients with mitral stenosis.[4] Once normal rhythm has been established, recurrences of auricular fibrillation are rare and are due usually to recurrent hyperthyroidism or to coincident cardiovascular disease.[5]

The occurrence of auricular fibrillation in the course of hyperthyroidism is not a simple result of the action of the excess thyroid secretion on the heart. It is encountered most commonly in older patients with hyperthyroidism and in those who have cardiac enlargement. Several factors must be at play: a structural or chemical alteration of the heart, thyroid intoxication, and increased work of the heart.

Although my patient had a slight hypertension and some left ventricular hypertrophy there was no dilatation of the auricles, and there had never been signs or symptoms of heart failure. Auricular fibrillation in hypertensive heart disease occurs only in the presence of considerable cardiac enlargement and heart failure. Thus the hypertension cannot have caused the irregularity. Nor was there a recurrence of the hyperthyroidism. Apparently, the auricles originally fibrillating in response to a thyrotoxicosis are now so conditioned that they revert to this irregular form of beating following an indifferent stimulus. This case suggests that, even when there has been an apparent cure of hyperthyroidism by subtotal thyroidectomy, an alteration of the metabolic processes of the heart muscle may persist, favoring a recurrence of auricular fibrillation.

1185 Park Avenue.

1. Kurtz, C. M.; Bennett, J. H., and Shapiro, H. H.: Electrocardiographic Studies During Surgical Anesthesia, J. A. M. A. **106:** 434 (Feb. 8) 1936.
2. Ernstene, A. C., and Mulvey, B. E.: A Study of Auricular Fibrillation Following Operations for Goiter, Am. J. M. Sc. **188:** 382 (Sept.) 1934.
3. Barker, P. S.; Bohning, A. L., and Wilson, F. N.: Auricular Fibrillation in Graves' Disease, Am. Heart J. **8:** 121 (Oct.) 1932.
4. Rosenblum, H. H., and Levine, S. A.: What Happens Eventually to Patients with Hyperthyroidism and Significant Heart Disease Following Subtotal Thyroidectomy, Am. J. M. Sc. **185:** 219 (Feb.) 1933.
5. Hurxthal, L. M.: Auricular Fibrillation in Patients with Goiter, Am. J. M. Sc. **179:** 507 (April) 1930.

A CASE OF STREPTOCOCCIC MENINGITIS WITH RECOVERY

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The subject of recovery from streptococcic meningitis was recently adequately reviewed by Gray.[1] He found sixty-five cases of recovery reported in the literature, to which he added his own case and made a plea for the report of other cases of streptococcic meningitis in which recovery occurred. I am therefore adding the following case:

REPORT OF CASE

F. U., a woman, aged 28, entered the Montefiore Hospital, Oct. 22, 1935, for a hemorrhoidectomy, which was performed the following morning under spinal anesthesia.

The past history was unimportant, except that two days previously she had fallen and injured the lower part of the back and the buttocks. At the time of the operation the buttocks still looked bruised, but the lower part of the back appeared normal. She also had an old sinus on the neck following removal of tuberculous glands in childhood, which yielded a staphylococcus on microscopic examination.

Fever, excruciating headache, pain in the back of the neck and vomiting developed October 24. The patient continued to vomit until and including the morning of the 27th. Her vomiting was forceful but not typically projectile.

1. Gray, H. J.: Streptococcic Meningitis, J. A. M. A. **105:** 92-96 (July 13) 1935.

I saw the patient October 27, at which time she complained of intense headache, pain in the back of the neck and vomiting.

Physical examination revealed rigidity of the neck, contracted pupils that did not react to light and in accommodation, irregular respirations, absence of abdominal reflexes, and a positive Kernig sign on the right.

The hyperesthesia of the lower extremities was so marked that they could barely be touched without the patient squirming. There was also some cyanosis of the fingertips.

A diagnosis of meningitis was made and a lumbar puncture ordered. The fluid from the spinal tap was cloudy, came out under pressure and contained 1,300 cells per cubic centimeter. The differential count showed 95 per cent polymorphonuclear leukocytes. A blood culture done the next day remained sterile.

The temperature rose to 103 F., ranged up to 104 for six days and then started to decline to normal, which level was maintained after six more days.

October 28 the patient complained of photophobia and the next day of double vision. I had started to tap the spinal canal every eight hours, removing only fluid under active pressure, while forcing dextrose solution by mouth, by enteroclysis and by hypodermoclysis. I did not inject the fluids intravenously because I preferred a slower absorption with a slower elimination.

October 29, with the temperature decreasing to 101 F., there was an abatement of all symptoms and the spinal fluid was getting clearer.

October 30 the spinal fluid appeared clear. The patient was subjectively free from complaint except as to vision and could move her neck freely from side to side. There was, however, considerable pain on pressure along the course of the nerves of the lower extremities.

October 31 the headache and rigidity of the neck recurred and the spinal fluid was again turbid. The following day the patient looked very toxic.

November 3 the temperature dropped to normal and after three days more remained at normal. With the drop in fever, the neck rigidity again became less and by the next day all symptoms were gone except for a doubtful Kernig sign on the right side. The spinal fluid was getting clear again.

November 4 the patient slept at long intervals and the spinal fluid was almost clear.

Facial neuralgia developed on the left side November 7, while there was twitching of the muscles of the right side of the face. By the 9th the patient had double vision only when looking to her left, and on the following day it was present only occasionally when her eyes felt tired. At this time she had quite a washed-out appearance.

A laboratory report of the spinal fluid disclosed a nonhemolytic streptococcus which grew poorly on subcultures and hence was of low virulence. Three cultures were done on different days and the same organism was recovered.

The fluid at the first tap was cloudy, then cleared up with an accompanying drop in fever and amelioration of all symptoms, only to become cloudy again with the return of all symptoms. The spinal fluid became clear a second time, when her temperature again dropped to normal, but was not absolutely clear with the last tap. Fibrin was present in the withdrawn fluid on several occasions. The amount withdrawn varied from 20 to 40 cc. The cell count varied from 1,300 to 450 on November 5, when the patient was free from symptoms.

The blood count showed a leukocytosis highest on October 27, when it was 23,400, with 92 per cent neutrophils.

Treatment consisted of spinal drainage every eight hours for the first four days, then twice daily until November 5, on which day only one tap was performed.

As already mentioned, 5 per cent dextrose in saline solution was injected subcutaneously and fluids were forced by mouth, and enteroclysis was also resorted to early in the treatment. On the average, the patient received close to 4 quarts (liters) of fluids daily. Milk, fruit juices, albumin, ice cream and thin gruels were given from the beginning, and as the patient's tongue was usually clean she was at times encouraged to take cooked vegetables. For the pain she received codeine hypodermically, one-half grain (0.03 Gm.) as her condition required, and occasionally whisky.

COMMENT

The interesting features of this case, aside from the recovery of the patient, were that it followed spinal anesthesia through recently traumatized tissue, and the symptoms in the course of the disease temporarily disappeared together with the clearing up of the spinal fluid, only to return later. It would be interesting to discover whether a remission in the course of meningitis is always accompanied by a clearing up of the spinal fluid.

When the symptoms first disappeared I was inclined to give the spinal drainage credit for the result, but when they recurred it left me in doubt. Yet the repeated drainage may have cleared up first one infected area and then another. I merely drained off enough fluid at certain intervals to keep the spinal pressure down while forcing fluids. No special claims are made for this method of treatment. I used no serums, no intravenous medication and no blood transfusions.

It must also be borne in mind that the organism was of low virulence, which fact might have played a large part in the patient's recovery.

Retan [2] did not find spinal drainage useful in streptococcic meningitis. The method I employed was not, however, the same as Retan's.

The patient was last examined Jan. 11, 1936, and no residuals were found. She stated, however, that since the meningitis a previous tendency to headache and insomnia has become more marked.

3401 Fifth Avenue.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

PAUL NICHOLAS LEECH, Secretary.

DEXTROSE (See New and Nonofficial Remedies, 1935, page 280).

The following dosage forms have been accepted:

Dextrose 5% in Distilled Water in Filtrair Container: Each 100 cc. contains dextrose, U. S. P., 5.50 Gm. Marketed in bottles containing 1,000 cc.

Prepared by Hospital Liquids, Inc., Chicago.

Dextrose 10% in Distilled Water in Filtrair Container: Each 100 cc. contains dextrose, U. S. P., 11.0 Gm. Marketed in bottles containing 1,000 cc.

Prepared by Hospital Liquids, Inc., Chicago.

Dextrose 25% in Distilled Water in Filtrair Container: Each 100 cc. contains dextrose, U. S. P., 27.5 Gm. Marketed in bottles containing 1,000 cc.

Prepared by Hospital Liquids, Inc., Chicago.

Dextrose 5% in Physiologic Sodium Chloride Solution in Filtrair Container: Each 100 cc. contains dextrose, U. S. P., 5.50 Gm. and sodium chloride, U. S. P., 0.85 Gm. Marketed in bottles containing 1,000 cc.

Prepared by Hospital Liquids, Inc., Chicago.

Dextrose 10% in Physiologic Sodium Chloride Solution in Filtrair Container: Each 100 cc. contains dextrose, U. S. P., 11.0 Gm. and sodium chloride, U. S. P., 0.85 Gm. Marketed in bottles containing 1,000 cc.

Prepared by Hospital Liquids, Inc., Chicago.

METRAZOL (See New and Nonofficial Remedies, 1935, p. 322).

The following dosage form has been accepted:

Hypodermic Tablets Metrazol 1½ grains: Each tablet contains metrazol sufficient to insure the administration of 1½ grains of metrazol in solution.

SAL ETHYL CARBONATE (See New and Nonofficial Remedies, 1935, p. 358).

The following dosage form has been accepted:

Compressed Tablets Sal-Ethyl Carbonate with Phenacetin: Each tablet contains sal-ethyl carbonate 0.23 Gm. (3½ grains) and phenacetin (acetophenetidin-U. S. P.) 0.1 Gm. (1½ grains).

TETANUS TOXOID, ALUM PRECIPITATED (See THE JOURNAL, May 16, 1936, p. 1735).

Lederle Laboratories, Inc., Pearl River, N. Y.

Refined Alum Precipitated Tetanus Toxoid-Lederle.—Marketed in packages of two 1 cc. vials (one complete immunization); and in packages of one 10 cc. vial (five complete immunizations).

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2. Retan, G. M.: The Development of the Therapeutic Use of Forced Perivascular (Spinal) Drainage, J. A. M. A. **105**: 1333-1339 (Oct. 26) 1935.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, JUNE 27, 1936

URINARY HISTIDINE IN THE DIAGNOSIS OF PREGNANCY

The early clinical diagnosis of pregnancy was greatly aided by the introduction of a laboratory test devised by Zondek and Aschheim in 1928. This test is based on an observation made in 1922 by Long and Evans, who demonstrated that intraperitoneal injections of fresh extract of the anterior lobe of the pituitary body caused an increase in weight of the ovaries of immature rats. Furthermore, large numbers of corpora lutea were formed in these ovaries. A short time later it was clearly established that the anterior pituitary exerted a powerful stimulant effect on the process of lutein cell formation.

Using these fundamental observations of Long and Evans and having demonstrated the presence of large amounts of gonadotropic substance in the urine of pregnant women, Zondek and Aschheim elaborated a technic for the diagnosis of pregnancy, basing their procedure on the detection of gonadotropic substance in the urine. The test involves the injection of portions of urine, over a period of forty-eight hours, into a group of infantile mice and a study of the ovaries of the injected animals at a definite time following the last injection. The ovaries are examined for ripening of follicles, for hemorrhagic points and for the formation of corpora lutea atretica. Utilizing this technic, Zondek and Aschheim found positive results in 98 per cent of the pregnancy cases tested. This test has yielded rather uniformly correct results in other laboratories and has been widely used in the clinical diagnosis of pregnancy. The Zondek-Aschheim test does have, however, the unfortunate feature of involving a considerable number of animals and of being relatively time consuming. Furthermore, the procedure is obviously best adapted to an adequate clinical laboratory and is of little aid to the practicing physician. In view of these difficulties, efforts have been made from time to time to develop a simple chemical test which might perhaps be carried out by the practitioner himself and which does not involve the use of animals.

One of the more promising of these devices appears to be the detection of urinary histidine, an amino acid which has been reported by Voge [1] to be absent from normal urine and present early in the urine of pregnancy. It is quite simple to conduct a chemical test for histidine, as this amino acid in solution gives, under definite conditions, a pink coloration on the addition of dilute bromine water. Voge has applied this test to a large number of urines and has compared the results obtained with those yielded by the application of the Zondek-Aschheim test to the same urines. The high degree of correlation between the results of the two methods has led to the suggestion that the bromine water test for histidine is of considerable aid in the diagnosis of pregnancy. This suggestion was supported by an actual isolation of histidine from pregnancy urine [2] and the demonstration that it was the presence of this amino acid in gravid urines that accounted for the positive bromine water reaction.

Several other investigators have been able to demonstrate a positive histidine test rather uniformly for pregnancy urine, and although the correlation with the Zondek-Aschheim test is not as good as that observed by Voge, the general uniformity of the results has indicated the value of a detailed study of the reaction. This has been initiated by Kapeller-Adler,[3] who, with collaborators, has had experience with the amino acid histidine. These Vienna investigators have applied a quantitative method, developed in their laboratory, to the determination of urinary histidine. It has been demonstrated that pregnancy urine may contain from 6 to 74 mg. per hundred cubic centimeters of this amino acid and that the compound is absent in the urine of normal men and women and in the various pathologic urines tested. In later investigations, these workers [4] have followed the excretion of histidine by a pregnant woman throughout the course of the pregnancy. The amino acid appeared in the urine at about the fifth week of gestation. The amount of urinary histidine was significantly greater on a meat diet, and orally administered histidine was eliminated unchanged. The excretion of this compound ceased on the third day post partum, and histidine given to the same individual several months later was completely metabolized. The authors present experiments which, they believe, support the hypothesis of an inhibition of the activity of liver histidinase in the liver of pregnant women; the failure of this enzyme to catalyze the catabolism of histidine would account for the presence of this amino acid in the urine.

These interesting results merit consideration, in view of the readiness with which the bromine water test can

1. Voge, C. I. B.: Brit. M. J. **2**: 829 (Nov. 2) 1929; Proc. Roy. Soc. Med. **23**: 638 (March) 1930.
2. Armstrong, A. R., and Walker, Ernest: Biochem. J. **26**: 143 (No. 1) 1932.
3. Kapeller-Adler, Regina: Biochem. Ztschr. **264**: 131 (Aug.) 1933.
4. Kapeller-Adler, Regina, and Schiller, W.: Klin. Wchnschr. **14**: 1790 (Dec. 7) 1935. Kapeller-Adler, Regina, and Haas, Fritz: Biochem. Ztschr. **280**: 232 (Sept.) 1935.

be conducted. However, a recent investigator [5] has cautioned against enthusiastic interpretation of the results obtained by the application of the histidine test for pregnancy. With a slightly modified bromine test it has been confirmed that the test for histidine is seldom positive in nonpregnant women. However, although frequently positive in urines from pregnant women, the significant number of negative tests on such urines makes the value of the reaction as a pregnancy test somewhat questionable. There appears to be a relationship between the likelihood of a positive reaction for histidine and the specific gravity of the urine, the intensity of the test varying directly with the magnitude of the specific gravity values. This relationship may merely be a manifestation of a limit to the concentration of urinary histidine that can be detected by the test. Further data must be secured in order to determine definitely whether this relatively simple chemical test for urinary histidine may be of at least some value in the clinical diagnosis of pregnancy. The ease with which the test is conducted should encourage thorough investigations of its value and significance.

HEMOLYTIC SHOCK AFTER BLOOD TRANSFUSION

The problem of hemolytic shock is assuming a greater theoretical and practical significance because of the wider adaptation of blood transfusion. Interesting clinical and experimental observations are analyzed by E. P. Gesse [1] in a review of twenty-two papers emanating from the First Surgical Clinic and the Research Institute for Blood Transfusion in Leningrad (E. P. Gesse, chief). According to Gesse and his co-workers, hemolytic shock is a complex concept of manifestations on the part of the blood vessels and the heart, accompanied by a depression of the nervous system and caused by transfusion of incompatible blood. They were able to demonstrate in animal experiments that [2] depressor substances released from the broken down erythrocytes act directly on the blood vessel wall, causing arterial spasm, dilatation of the capillary bed, stasis and a sharp fall in the blood pressure. The cardiac action is secondarily affected as the result of insufficient flow of blood to the heart during the diastole. The manifestations are, as a rule, quickly compensated and are succeeded by a secondary phase provoked by the spasm of the renal arteries and the hemolysis. Derangement of the renal function ensues as the result of toxic action of the products of broken down red cells.

Gesse was able to collect 217 cases of hemolytic shock following blood transfusion. These were recorded in the literature and in replies to 1,700 questionnaires sent out to large hospitals and clinics. In his own series of 2,360 transfusions there were six instances of hemolytic shock (0.25 per cent). The mortality rate for the collected group amounted to 56 per cent. Hemolysis occurred occasionally after transfusion of compatible, conserved blood. It was due either to the hemolysis of the conserved blood, to its being overheated, or to the denatured albumins. The older the blood the greater was the danger of hemolysis.

Excruciating pain in the lumbar region is the most characteristic, in fact, the pathognomonic subjective symptom of hemolytic shock. It is caused by the spasm of the renal arteries, is ischemic in nature and cannot be controlled by morphine. The most important objective signs are the fall in the blood pressure and the increased intestinal peristalsis. Gesse suggests a classification of cases into an acute form with mild and with severe manifestations, and a delayed form. Hemolytic shock results, as a rule, from transfusion of a large amount of incompatible blood. Cases, however, were reported in which fatal shock followed the transfusion of small doses. In forty-six cases, shock developed after transfusion of blood from a universal donor. Possibility of hemolysis is to be kept in mind when amounts larger than 200 cc. of blood from a universal donor are to be used, when the recipient exhibits a severe anemia, and in the presence of a high serum titer of the donor with regard to the recipient's erythrocytes.

A satisfactory method of dealing with the hemolytic shock of blood transfusion did not exist prior to 1932. Intravenous administration of dextrose exerted in some cases a powerful diuretic effect. Decapsulation of the kidneys did not prove successful. In 1932 Filatov and Gesse [3] suggested the method of secondary transfusion with compatible blood as the method of treatment of hemolytic shock. The authors transfused dogs with fatal doses of hemolyzed blood, causing a maximal fall in the blood pressure and cessation of respiration. Transfusion with compatible homogeneous blood revived the animals. The method was applied in human beings in sixteen instances with fourteen recoveries. The secondary transfusion should be performed at the earliest possible moment after the development of hemolytic shock. The method, however, was successful in four cases in which secondary transfusion with compatible blood was undertaken from twenty-four to forty-eight hours after the onset of the symptoms. Amounts of from 200 to 300 cc. of compatible blood are sufficient for the purpose of detoxication, although the arterial spasm is relaxed after the infusion of from 25 to 30 cc., as evidenced by the prompt cessation of the excruciating lumbar pain. Large amounts are contraindicated in the presence of a renal lesion. When hemoglobinuria and anuria are present, the intravenous administration of dextrose is indicated.

5. Földes, Franz: Biochem. Ztschr. **283**: 199 (Jan.) 1935.

1. Gesse, E. P.: The Nature and the Treatment of Hemolytic Shock After Blood Transfusion, Vestnik Khirurgii **41**: 59 (No. 114).

2. Gesse, E. P., and Filatov, A. N.: Experimental Studies on Alterations in Organism in Hemolysis, Vestnik Khirurgii, 1932, pp. 80-81; Ztschr. f. d. ges. exper. Med. **86**: 211 (Jan. 2) 1933.

3. Gesse, E. P., and Filatov, A. N.: Neue practische Ausblicke auf die Möglichkeit der Behandlung des hämolytischen Schocks bei der Bluttransfusion im Lichte experimenteller Forschung, Zentralbl. f. Chir. **59**: 2674 (Nov. 5) 1932.

SEPTICEMIA DUE TO ANAEROBIC ORGANISMS

In 1935 Pham-Huu-Chi,[1] according to Lemierre,[2] published a heavily documented monograph on certain septicemias due to anaerobic organisms. This work, being a special thesis, is difficult to obtain; fortunately a brief summary now exists in English in an address by Lemierre.[2] Several species of anaerobic organisms, specifically distinct from one another but possessing the common character of living as saprophytes in the natural cavities of the human body, can cause these special septicemias. All these organisms are fragile, are slightly motile, and grow only sparsely on culture mediums. To this group of organisms belong those gram-negative and non-spore bearing bacilli which certain bacteriologists group together under the name of Bacteroides. With them must also be placed several gram-positive anaerobic streptococci and staphylococci, which have been variously named.

A septicemia with these organisms arises from inflammatory or suppurative lesions in the tissues or cavities where the organisms normally exist under physiologic conditions. The most common locations for these inflammatory lesions are the nasopharynx, particularly tonsillar and peritonsillar abscesses, similar regions of the mouth and jaws, the urinary passages and the structures involved in otitis media or mastoiditis, purulent endometritis following parturition, and appendicitis. Whatever the origin, according to Lemierre, the inflammatory lesions present certain common clinical aspects that enable them to be grouped together. The postanginal septicemias due to anaerobic organisms most frequently seen in Paris are due particularly to Bacillus funduliformis, which can usually be isolated in pure culture from the blood and from secondary abscesses. The bacillus is sometimes associated with an anaerobic streptococcus.

Clinically the disease usually affects young adults or adolescents, and the two sexes about equally. It has been believed since 1919 that these septicemias are the result of a thrombophlebitis of the tonsillar and peritonsillar veins, which can spread to the internal jugular vein or even to the facial vein. Lemierre agrees with this opinion. The first symptom is a notable rise of temperature to 103 F., often with rigors. There is usually painful swelling of the glands below the maxillary angle, generally unilateral. Most of the septicemias are accompanied by the formation of distant metastatic abscesses. The abscesses are commonly located in the lungs and may occur quite early. They are septic infarcts, leading almost invariably to multiple abscess formation with intense thoracic pain, dyspnea, sometimes blood-stained sputum, pleural frictions, and localized areas of subcrepitant râles. Articular lesions are frequent. Icterus has often been noted. Renal lesions, thyroid lesions and metastatic lesions almost everywhere have sometimes occurred. Fatal progress may occur rapidly. The final diagnosis is established by bacteriologic examination. Bacillus funduliformis is easy to discover in the purulent effusions, but blood culture on anaerobic mediums gives the earliest definite information. Positive results are particularly easy if the blood is taken during a chill. The treatment has been discussed elsewhere by Lemierre and Pham.[3] Intravenous injection of acridine yellow and blood transfusions have not seemed to influence the course. Furthermore, great hopes cannot be founded on specific serotherapy, since attempts to immunize animals have resulted in poor antibody production. At present the medical treatment must remain purely symptomatic.

There is a definite similarity between the anaerobic septicemias arising from the other organs of the body. Frequently Bacillus funduliformis is also a saprophyte in the pelvic organs, the appendix or the ear. Hence localized inflammations in these organs may also result in anaerobic septicemia. Septicemias with other anaerobic organisms, such as B. fragilis, B. radiiformis, B. ramosus, B. fusiformis and B. symbiophiles, have also been described. The apparent rarity of the disease in this country may cease with a more frequent recognition of the possibility of septicemias being due to organisms of this group.

1. Pham-Huu-Chi: Les septicémies dues au Bacillus funduliformis, Thèse de Paris, 1935.
2. Lemierre, A.: On Certain Septicemias Due to Anaerobic Organisms, Lancet **1**: 701 (March 28) 1936.
3. Lemierre, A., and Pham-Huu-Chi: Les septicémies à Bacillus funduliformis, J. de méd. et chir. prat. **106**: 153 (March 10) 1935.

Current Comment

PRESSURE IN COMMON DUCT AND RELIEF OF PAIN FOLLOWING CHOLECYSTECTOMY

Elsewhere in this issue [1] are probably the first two reports published of direct observations and measurements of pressure in the common bile duct of man. The observations reported by Kipp were made on a man with a benign stricture of the common duct at the ampulla of Vater on whom he had performed a cholecystogastrostomy. Kipp also demonstrated clinically that certain extrinsic factors influenced the flow of bile in this patient. McGowan, Butsch and Walters made their observations on patients on whom a cholecystectomy had been performed. Many years ago Judd and Mann [2] demonstrated experimentally the dilatation of the common bile duct that follows removal of the gallbladder. Nearly ten years later Potter and Mann [3] measured in the laboratory the increase in intraductal pressure following removal of the gallbladder. Now, McGowan, Butsch and Walters,[1] with the cooperation

1. Kipp, H. A.: Observations on the Variations in Bile Pressure in the Human Biliary Tract, this issue, p. 2223. McGowan, J. M.; Butsch, W. L., and Walters, Waltman: Pressure in the Common Bile Duct of Man: Its Relation to Pain Following Cholecystectomy, this issue, p. 2227.
2. Judd, E. S., and Mann, F. C.: The Effects of Removal of the Gallbladder: An Experimental Study, Surg., Gynec. & Obst. **24**: 437 (April) 1917.
3. Potter, J. C., and Mann, F. C.: Pressure Changes in the Biliary Tract, Am. J. M. Sc. **171**: 202 (Feb.) 1926.

of patients, have not only shown that what is true of intraductal pressure of animals also is true of intraductal pressure of man but they have demonstrated that morphine, the therapeutic standby for postcholecystectomy colic, actually makes worse the condition that causes the pain. Of course, the pain disappears following administration of morphine just as it would if a black-jack had been employed; the sensory part of the brain ceases to function but the intraductal pressure rises. With the administration of a nitrite, pressure within the common bile duct drops and pain ceases. Now, therefore, the results of the long research become applicable in the everyday work of the physician. This applicability in itself is sufficiently important. However, it illustrates again the interdependence of the sciences and of the medical specialties. Surgeons, in these reports from the bedside, have contributed to drug therapy and pointed out new paths of investigation for the pharmacologists, one of which is to determine whether biliary colic after administration of morphine is attributable to malfunction of the sphincter of Oddi or to closure of the intraduodenal portion of the common bile duct consequent on increased duodenal peristalsis.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

ARIZONA

Personal. — Dr. Willis D. Gilmore, Tombstone, has been appointed tuberculosis consultant for the Arizona State Board of Health.——Dr. Jack B. Eason, Tucson, health officer of Pima County, has been placed in charge of the new health unit in Yuma County.

CALIFORNIA

Society News.—Dr. Clifford V. Mason, Livermore, among others, addressed the Alameda County Medical Association in Oakland, June 15, on "Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis." —— Dr. Frederick Proescher, San Jose, addressed the Los Angeles Society of Neurology and Psychiatry, June 17, on "The Nature of the Neurotropic Viruses, Rabies and Poliomyelitis."——At a meeting of the Hollywood Academy of Medicine, May 21, Aberdeen O. Bowden, Ph.D., Los Angeles, discussed "Early Medicine and Its Relation to Magic and Religion."

Tuberculosis Death Rate Lowered. — There were 4,516 deaths from tuberculosis registered in California in 1935 as compared with 4,611 deaths in 1934, giving rates of 72 and 74.9, respectively, per hundred thousand of population. Of the 4,516 persons, 3,179 had lived within the state for ten years or more, 576 had lived in California from five to nine years, 357 from one to four years, and 186 had lived in the state for less than one year. Of this group, 4,105 deaths were attributed to tuberculosis of the lungs, 131 to tuberculosis of the meninges and 103 to disseminated tuberculosis.

CONNECTICUT

Anniversary of Health Bulletin.—The *Connecticut Health Bulletin* celebrated its fiftieth anniversary with the May issue. The bulletin reproduces various covers and pages from its earlier issues. The first number of the bulletin appeared in June 1887 and it has been printed continuously since that time.

Expansion of Health Department.—Federal funds granted under the Social Security Act have made possible two new positions in the Connecticut State Health Department, it is reported. Franklin M. Erlenbach, Boston, will fill the newly created position of chief of the division of mouth hygiene in the bureau of child hygiene, and Mrs. Helen S. Peterson, New York, the new position of assistant mental hygienist in the bureau of mental hygiene. Under the new arrangement Miss Anna Katherine Tobias, formerly of West Hartford, has been named librarian of the department. Dr. Henry P. Talbot, who has been studying for the past year at the Harvard School of Public Health, was to return June 1 as director of the bureau of venereal diseases; he was on leave of absence. Dr. Alfred L. Burgdorf, acting director of the bureau, will be transferred to the bureau of preventable diseases.

FLORIDA

New Health Units.—The Gadsden County Health Department was recently organized with headquarters in Quincy. Dr. Charles W. McDonald, formerly director of county health work, Alabama State Department of Health, it is reported, is in charge of the new unit. Dr. Herbert A. McClure is health officer of the newly created health department in Taylor County, with headquarters in Perry.

ILLINOIS

Outbreak of Smallpox.—According to the state department of health, seventeen new cases of smallpox were reported in Will County during the week ended June 1. Three cases were reported in Whiteside County. The twenty new cases during this week compare with four for the corresponding week last year, while 251 cases have been reported for this year against thirty-six for the similar period of 1935.

Society News. — Dr. Winston H. Tucker, Springfield, addressed the thirty-seventh annual meeting of the Sangamon County Medical Society in Springfield, June 4, on "Diagnosis and Treatment of Poliomyelitis."——Dr. George D. Hauberg, Moline, was chosen president of the Iowa-Illinois Medical Association at its annual meeting in Davenport, May 26.——Dr. Richard H. Jaffé, Chicago, discussed "Precancerous Lesions" before the Peoria City Medical Society, June 16.

Chicago

Personal.—Dr. Walter W. Hamburger, whose resignation as assistant clinical professor of medicine at Rush Medical College was recently announced, will remain at the Department of Medicine, University of Chicago, as clinical professor of medicine.

Dr. Meek Gives Luckhardt Lecture.—Walter J. Meek, Ph.D., department of physiology, University of Wisconsin School of Medicine, Madison, delivered the third annual lecture under the Arno B. Luckhardt Lectureship at the University of Chicago, May 21. His lecture was entitled "A Present Day Concept of Shock." The lectureship was established in the medical school by the Delta chapter of Phi Beta Pi.

Amateur Night and Annual Banquet.—The annual banquet of the Chicago Medical Society with the installation of officers took place June 17. Dr. Julius H. Hess, retiring president, made a brief address and installed Dr. Thomas P. Foley as president. The president-elect is Dr. George W. Post. On behalf of the society Dr. Charles H. Phifer presented Dr. Hess with a fine camera. The entertainment included an amateur night at which all the performers were either physicians or members of the families of physicians.

Rush Medical College of the University of Chicago.—At the annual faculty alumni dinner at Rush Medical College, June 16, announcement was made by Vice President Frederic Woodward for the university that the School of Medicine of the Division of Biological Sciences at the University of Chicago and Rush Medical College are now combined in one institution to be known as the Rush Medical College of the University of Chicago. Undergraduate medical education will be continued at the west side school. The medical schools are united in one departmental organization under the dean of the biological sciences. On the west side Dr. Emmet B. Bay will be associate dean. It is proposed within the next five years to diminish the number of medical students greatly and to introduce graduate instruction on an increasing scale into the curriculum with the possibility that eventually graduate study will supersede undergraduate study entirely on the west side. An ovation was tendered to Dr. Ernest E. Irons, who retires as dean to assume the title of professor of medicine. He will remain as chairman of the department of medicine. In his address Dr. Irons pointed out that 1937 will mark the centennial of the charter of Rush Medical College and it is proposed to celebrate the occasion fittingly at the time of the 1937 convocation. A committee was appointed to draw up plans for the celebration of the centennial with Dr. Robert H. Herbst as chairman.

INDIANA

University News.—An anonymous donor has given a collection of medical memorabilia to the museum of Indiana University School of Medicine, Indianapolis. The collection includes a volume of original notes made by Dr. Robert Cravens of Madison when attending lectures given, among others, by Dr. Caspar Wistar, who published the first American "System of Anatomy"; on materia medica by Dr. Nathaniel Chapman; on surgery by Dr. Physick and Dr. Dorsey, and on midwifery and the diseases of women and children by Dr. Thomas Chalfley James. Original signatures of the lecturers are included in the collection. Dr. Cravens died in 1821.

District Meetings.—At a meeting of the Eleventh Indiana Councilor District Medical Association in Marion, May 20, Drs. Andrew L. Banyai, Wauwatosa, Wis., spoke on "Childhood Tuberculosis"; Lall G. Montgomery, Muncie, "Primitive Tubercle"; Arthur B. Richter, Flora, "Treatment of Nephritis," and James Charbonnier, B.D., Upland, head of the department of theology and classical languages of Taylor University, "Present European Situation."——The Ninth Councilor District Medical Society was addressed in Lafayette, May 19, by Drs. Frederick A. Coller, Ann Arbor, "The Acute Abdomen"; Jerome R. Head, Chicago, "Treatment of Acute and Chronic Empyema"; William H. Park, New York, "Management and Control of the Communicable Diseases," and Robert J. Masters, Indianapolis, "The Ophthalmoscope as a Help in Diagnosis of Disease."——At a meeting of the Union District Medical Association in Newcastle, May 28, Mr. Albert Stump, Indianapolis, discussed "The Doctor and the Law"; Drs. Max M. Zinninger, Cincinnati, "Treatment of Acute Head Injuries"; Larue D. Carter, Indianapolis, "The Neuroses"; Charles J. McIntyre, Indianapolis, "Observation in Tuberculosis," and George Wiggins, Newcastle, "Industrial Dermatitis."——The Sixth District Medical Society was addressed in Shelbyville, May 21, by Drs. Joseph L. Allen, Greenfield, who gave the address of welcome; Johnson McGuire, Cincinnati, "Cardiac Irregularities and Treatment"; Louis H. Segar, Indianapolis, pediatrics; Homer H. Wheeler, Indianapolis, "Rectal Diseases Most Frequently Encountered in Practice"; Howard B. Mettel, Indianapolis, "Relation of Indiana Bureau of Maternal and Child Health to Local Medical Society," and Bayard G. Keeney, Shelbyville, cancer.

LOUISIANA

Personal.—Dr. Hilliard E. Miller, assistant professor of gynecology, Tulane University of Louisiana School of Medicine, New Orleans, has been appointed chief of the department of gynecology at Touro Infirmary, succeeding his brother, the late Dr. Charles Jefferson Miller.

Society News.—At a meeting of the Orleans Parish Medical Society in New Orleans, May 25, speakers were Drs. James Ross Veal and Benjamin D. D. Van Werden on "Postoperative Pulmonary Complications"; Manuel Gardberg, "Diabetic Infection and Gangrene," and Henry Theodore Simon, "Rôle of the Semilunar Cartilage in the Football Knee." At a special meeting of the society, April 20, Drs. Horton R. Casparis, Nashville, Tenn., discussed "Child Tuberculosis"; Max Pinner, Oneonta, N. Y., "Diagnostic and Prognostic Significance of Negative Sputum"; Paul P. McCain, Sanatorium, N. C., "Epidemiologic Aspects of Tuberculosis," and Lewis J. Moorman, Oklahoma City, "Compression Therapy."

MAINE

Society News.—At a meeting of the Kennebec County Medical Association in Togus recently the speakers included Drs. Hanson T. Perkins, on "Diagnosis of Myocarditis"; James H. Pennington, "Report of a Series of Cases of Chronic Appendicitis"; Joseph E. Wheeler, "Amputations," and Harry Levine, "Nephritides."

MICHIGAN

Personal.—Dr. George P. Myers, Detroit, has been appointed chief surgeon of the Michigan Central Railroad and acting medical director of the New York Central system, succeeding the late Dr. William L. Hartman.

County Societies and Medical Economics.—To aid in the adoption of a statewide program of medical economics the chairman of the medical economics committee of the state medical society has sent a letter to the officers of every county medical society urging a survey of this subject in their territory. The committee desires to know what the societies have done during the past twelve months and what they hope to accomplish in the next year.

Society News.—Dr. Frederick G. Buesser, Detroit, discussed "Medical Treatment of Peptic Ulcer" before the Lapeer County Medical Society recently.——The St. Clair County Medical Society was addressed, May 19, on "Practical Value of Intravenous Urography."——Dr. Alfred H. Whittaker, Detroit, was elected president of the Michigan Industrial Physicians and Surgeons' Association at its annual meeting in Jackson, May 8; Dr. Donald F. Kudner was reelected secretary and Detroit was selected as the place for the 1937 meeting.

MINNESOTA

Society News.—Dr. John Richards Aurelius, St. Paul, was chosen president of the Minnesota Radiological Society at its recent annual meeting; Dr. Walter H. Ude, Minneapolis, vice president, and Dr. Leo G. Rigler, Minneapolis, secretary. Dr. Willis F. Manges, Philadelphia, discussed "The Future of Radiology" at the annual dinner.——Dr. Thomas B. Cooley, Detroit, addressed the Northwestern Pediatric Society in St. Paul, May 7, on "Constitutional Hemolytic Anemias."——At the annual dinner of the Red River Valley Society in Crookston recently Dr. William T. Peyton, Minneapolis, spoke on "Tumor of the Breast."

Personal.—Dr. James R. Kingston, Deer River, has been appointed director of public health for the northern Minnesota district, with headquarters in Grand Rapids; he will share his practice in Deer River with another physician.——Dr. Arrah B. Evarts, senior assistant physician, Rochester State Hospital, resigned June 1. She was presented with a gift of silver, May 15, by the employees of the hospital, with which she had been associated since 1918.——Dr. Charles E. Lyght, assistant professor of medicine and acting chief of student health, University of Wisconsin Medical School, Madison, has been appointed professor of health and director of physical education for men at Carleton College, Northfield.

MISSOURI

Society News.—Dr. Thomas G. Orr, Kansas City, addressed the Buchanan County Medical Society in St. Joseph, June 3, on "Treatment of Disease of the Gall Tract."——Dr. Arthur E. Hertzler, Halstead, Kan., addressed the St. Louis County Medical Society, June 24, on "Effects of Total Thyroidectomy with Differentiation Between the Degenerative Toxicity and the Hyperplastic Toxicity"; the St. Louis Medical Society was invited.——Dr. Edmund Henry M. Lissack, Concordia, read a paper on "Breech Presentation" before the Johnson County Medical Society, May 13.

NEW YORK

Syracuse Alumni Meeting.—The Medical Alumni Association of Syracuse University School of Medicine held its annual meeting June 1-2. Demonstrations were presented at the University Hospital of the Good Shepherd, St. Joseph's and Syracuse Memorial hospitals. Dr. Anton J. Carlson, professor and chairman of the department of physiology, University of Chicago, was a guest speaker at a luncheon meeting and at a banquet in the evening.

Society News.—Dr. Harold E. Himwich, Albany, addressed the Medical Society of the County of Albany, May 27, on "Blood Sugar in Diabetes."——The Medical Society of the County of Saratoga held its annual spa therapy meeting at Saratoga Springs June 4. Speakers were Drs. Richard Kovacs, New York, on "Newer Methods of Heat Therapy"; Lee A. Hadley, Syracuse, "Diagnosis and Physical Therapy Treatment of Certain Painful Conditions of the Back"; Ralph Pemberton, Philadelphia, and Robert B. Osgood, Boston, medical and surgical aspects, respectively, of arthritis.——Dr. George W. Crile, Cleveland, addressed the Utica Academy of Medicine, May 14, on "Genesis and Treatment of Essential Hypertension."——Dr. Edward D. Churchill, Boston, addressed the Glens Falls Academy of Medicine, May 14, on "Lobectomy, Pneumonectomy and Thoracoplasty."

New York City

Personal.—Dr. Thomas Hodge McGavack, formerly of the University of California Medical School, San Francisco, has been appointed associate professor of medicine, beginning July 1, at the New York Medical College and Flower Hospital.

Society News.—Health officers of the metropolitan area, including parts of New Jersey and Connecticut, formed the Metropolitan Health Officers' Conference at a meeting, June 5, at the New York City Department of Health building. Dr. Matthias Nicoll Jr., health commissioner of Westchester

County, was made temporary chairman and Dr. Charles F. Bolduan, of the New York health department, temporary executive secretary.

Hospital News.—Dr. Max Seide has been appointed superintendent of Cumberland Hospital, Brooklyn, to succeed Dr. Marcus D. Kogel.——Dr. Jack Masur has been appointed assistant director of Montefiore Hospital to succeed Dr. Morris Hinenburg, now medical director of the Brooklyn Jewish Hospital.——Dr. Carlos Monge of the Faculty of Medicine, Lima, Peru, and a member of the International High Altitude Expedition, discussed "Studies in High Altitudes: Chronic Mountain Sickness" at Mount Sinai Hospital, May 1.

Dr. Park to Retire from New York University.—Dr. William H. Park, Biggs professor of preventive medicine and director of bacteriological laboratories, New York University College of Medicine, has been granted a leave of absence for the session of 1936-1937 and will retire after that period. Dr. Park, who is now 72 years old, has been connected with the university since 1895. He was professor of bacteriology and hygiene from 1900 to 1933, when he received his present title. In the session of 1914-1915 he was dean of the school. Dr. Park, for many years director of the department of laboratories of the New York City Department of Health, reached the retirement age for that position Dec. 20, 1933, but his term of service was extended and was again extended, June 5, to September 30.

OKLAHOMA

Society News.—Drs. Everett S. Lain and Minard F. Jacobs, Oklahoma City, conducted a cancer clinic as guests of the Woods-Alfalfa Counties Medical Society in Cherokee, May 26.——Dr. Raymond G. Jacobs, Enid, addressed the Garfield County Medical Society, April 30, on "Fractures of the Long Bones."

Personal.—Joseph B. Goldsmith, Ph.D., has been promoted to be associate professor of histology and embryology at the University of Oklahoma School of Medicine, Oklahoma City.——Dr. Joseph B. Carmichael, Duncan, has been appointed health officer of Stephens County to succeed the late Dr. Dock Long, Duncan.

PENNSYLVANIA

Society News.—The fourth monthly graduate assembly of the Montour County Medical Society at Danville, June 5, consisted of a symposium on diseases of the eye, ear, nose and throat by Drs. George H. Cross, Chester; Frank C. Hammond, Philadelphia; John R. Simpson, Pittsburgh, and Francis W. Davison, Danville. Dr. Alexander H. Colwell, Pittsburgh, president, Medical Society of the State of Pennsylvania, gave an address and Dr. Harold L. Foss conducted an operative clinic.——The spring meeting of the central Pennsylvania branch of the Society of American Bacteriologists was held at Geisinger Memorial Hospital, Danville, May 16. Among speakers were Drs. Francis W. Davison, on "Clinical Manifestations of Bacterial Sensitivity" and John F. Conway, "Value of Premedical Training in Bacteriology."——Drs. Eben W. Fiske and Harold W. Jacox, Pittsburgh, conducted a seminar on physical therapy at Waynesburg, June 9, for the Greene County Medical Society under the auspices of the committee on physical therapy of the Medical Society of the State of Pennsylvania.——Dr. Ralph Pemberton, Philadelphia, addressed the Lehigh County Medical Society, Allentown, in April, on the treatment of arthritis.——Dr. I. Newton Kugelmass, New York, addressed the York County Medical Society, June 20, on "Blood Dyscrasias in Infancy and Childhood."

Philadelphia

Society News.—Dr. William D. Stroud was recently elected president of the Philadelphia Heart Association.——Dr. Albert E. Bothe addressed the Philadelphia Urological Society, May 25, on "Benign Hypertrophy of the Prostate with Tuberculosis." Dr. Bothe was elected president.

Personal.—Dr. Louis Tuft has been appointed to succeed Dr. John L. Laird as head of the laboratory in the state department of health.——Dr. P. Brooke Bland received the honorary degree of doctor of science at the commencement exercises of Franklin and Marshall College, Lancaster, June 3.

Jefferson Alumni Dinner.—The annual dinner of the Alumni Association of Jefferson Medical College was held at the Bellevue-Stratford Hotel, June 4, with more than 500 alumni present. Dr. Charles E. G. Shannon, president of the association, presided and speakers were Mr. Van Horn Ely, a trustee of the college; Dr. David M. Davis, professor of genito-urinary surgery; Dr. James W. Tankersley, Greensboro, N. C., representing the class of 1906; Dr. Andrew Wallhauser, Pittsburgh, the class of 1916; Dr. Neal R. Moore, Bay City, Mich., the class of 1926, and Dr. Leonard W. Parkhurst, Wilkes-Barre, the class of 1936.

RHODE ISLAND

Personal.—Dr. Henry Antonio Rosa has been named medical examiner in Portsmouth. Dr. Ralph J. Petrucci has been appointed medical examiner for the towns of Barrington and Warren.——Dr. Seth F. H. Howes, assistant superintendent of the State Infirmary, Howard, has been appointed superintendent to succeed Dr. Karl B. Sturgis.

TENNESSEE

Society News.—Dr. Raymond Wallace addressed the Hamilton County Medical Society, Chattanooga, June 4, on "Recent Trends in Gynecologic Surgery."——Drs. George J. Sells and Raymond D. Tompkins, Johnson City, addressed the Washington County Medical Society, May 7, on angioneurotic edema and pain in the heart, respectively.——Dr. Jarrell Penn, Knoxville, discussed acute injuries to the back, May 5, at the meeting of the Knox County Medical Society, Knoxville.——Dr. George A. Hendon, Louisville, Ky., addressed the Nashville Academy of Medicine, May 26, on "Treatment of Fractures, with Special Reference to Ununited Fractures."——Drs. Robert L. Sanders and Thomas C. Moss addressed the Memphis and Shelby County Medical Society, May 5, on "Clinical Observations in 100 Cases of Cyclopropane Anesthesia" and "Aberrant Endometrium" respectively. Speakers at a meeting May 18 were Drs. David H. James and Joseph H. Francis on "Megacolon" and "Sympathetic Ophthalmia" respectively.

VIRGINIA

Personal.—Dr. Charles Howe Eller, Charlottesville, has resigned as health officer of Albemarle County to become assistant director of rural health with the state health department, it is reported, and Dr. Adrian L. Carson, health officer of Fairfax County, has been made director of the bureau of maternal and child hygiene. Dr. Edward M. Holmes Jr., Richmond, has been appointed health officer for Fairfax County to succeed Dr. Carson.

Society News.—Speakers who addressed the Southside Virginia Medical Association at its quarterly meeting in South Hill, June 9, were the following Richmond physicians: Drs. Arthur S. Brinkley, on "An Unusual Case of Intestinal Obstruction"; William Lowndes Peple, "Radium in the Treatment of Nonmalignant Uterine Conditions"; Douglas G. Chapman, "Mechanism and Electrocardiographic Registration of Heart Beat in Health and Disease"; Paul D. Camp, "Clinical Diagnosis of Irregularities of the Heart," and William R. Jordan, "Care of the Feet in Diabetes."

WISCONSIN

Society News.—Drs. Paul F. Doege, Marshfield, and Edwin G. Bannick, Rochester, Minn., addressed the annual meeting of the Ninth Councilor District of the State Medical Society of Wisconsin, May 7, at Stevens Point, on "Determination of Degrees of Malignancy as Applied to the Uterine Cervix" and "Treatment of Nephritis" respectively.——Drs. Arlie R. Barnes and Harry M. Weber, Rochester, Minn., addressed the April meeting of the Eau Claire-Dunn-Pepin County Medical Society on "Pulmonary Embolism: Its Effect on the Heart and Its Clinical Recognition" and "Roentgenologic Manifestations of the More Commonly Encountered Lesions of the Large Intestine" respectively.——Dr. Frank J. Hirschboeck, Duluth, Minn., addressed the Douglas County Medical Society, May 13, on "The Nervous Patient."——Dr. Edward K. Steinkopff, Pewaukee, addressed the Washington-Ozaukee County Medical Society, May 7, on modern treatment of tuberculosis.——Speakers at a meeting of the Milwaukee Society of Clinical Surgery, May 6, were Drs. Leland S. McKittrick, Boston, on "Management of Deep Infections of the Hand in Patients with Diabetes Mellitus"; Harry P. Ritchie, St. Paul, "Congenital Clefts of the Face and Jaws—Problems of Repair" and William J. Carson, Milwaukee, "Tuberculous Appendicitis."——Dr. Cyril G. Richards, Kenosha, was elected president; Dr. Harry E. Kasten, Beloit, vice president, and Dr. Sidney J. Silbar, Milwaukee, secretary, of the Wisconsin Urological Society at the annual meeting in Marshfield, April 23.

PUERTO RICO

University News.—Dr. James W. Jobling of the department of pathology, Columbia University College of Physicians and Surgeons, represented the university at the annual meeting of the board of trustees of the School of Tropical Medicine at the University of Puerto Rico, which is conducted under

the auspices of Columbia. Dr. Chung-Un Lee, Peiping Union Medical College, Peiping, China, is spending some time at the school carrying out investigations of diseases caused by parasites.

GENERAL

Council on Birth Control.—The National Medical Council on Birth Control has recently been formed to control and supervise medical policies of the American Birth Control League and to initiate, encourage and execute appropriate scientific research in the medical aspects of birth control. Dr. Frederick C. Holden, New York, is chairman and Dr. Eric M. Matsner, New York, executive secretary of the executive committee. Other members are Drs. Eliot Bishop, Brooklyn; Foster Kennedy, Edgar Mayer, Richard N. Pierson and Wilbur Ward, New York; Abraham N. Creadick, New Haven; Owen J. Toland, Philadelphia, and Prentiss Willson, Washington, D. C.

French Information Center.—The formation of the "French Information Center," with headquarters in New York and Paris, is announced. Representatives of various French and American activities have formed an association, by which the project will be financed. Membership is open to both French and American institutions, corporations and individuals. The New York office plans to keep on file reference books, statistics, periodicals and newspapers covering a wide range of questions and will attempt to gather documents not to be found in America at present or not easily accessible. The New York office announces that it has received a quantity of documentary material pertaining to French medicine and will be glad to place this material at the disposal of American physicians and aid them in any problem they may have concerning medicine in France.

Changes in Status of Licensure.—The state board of medical education and licensure of Pennsylvania recently reported the following action:

License of Dr. Richard P. Jahnig, whose last known address was Pottstown, Pa., suspended indefinitely, April 16, because of violation of the narcotic laws.

The New Jersey board of medical examiners reported the following action:

License of Dr. James M. Hackett, Leonia, N. J., revoked March 18, for conviction of the crime of criminal abortion.

The California State Board reported the following actions taken at the meeting, March 9-12:

Dr. Woodward B. Mayo, Los Angeles, license revoked for violation of probation.

Dr. Walter F. Pike, Oakland, placed on probation for five years without narcotic privileges.

Dr. William N. Powers, Los Angeles, license revoked for conviction of a felony.

Dr. Robert Bremner Smith, Yountville, license revoked for federal narcotic conviction.

Dr. Carl W. Wahrer, Seymour, Iowa, formerly of Sacramento, license revoked for federal narcotic conviction.

Bequests and Donations.—The following bequests and donations to medical institutions have recently been announced:

Lincoln Hospital, New York, $1,000 by the will of the late Henry Wollman.

Paterson (N. J.) General Hospital, $15,000 and its junior auxiliary, $5,000 by the will of Mrs. Louise J. E. Whitehead.

United Hospital Fund, the residuary estate of the late Reid A. Kathan, estimated in 1929 at $727,660, under the recently filed will of his widow.

Mount Sinai Hospital, $25,000; New York Eye and Ear Infirmary, Lenox Hill and Montefiore hospitals, $20,000 each; Beth Israel Hospital, $15,000, and New York Polyclinic Hospital, $10,000 by the will of Mrs. Madeleine S. Stern. All the hospitals are in New York.

University of Cincinnati College of Medicine, $5,000 from Mrs. Christian R. Holmes for research in internal medicine and $4,000 from Miss Mary Hanna to purchase 100 mg. of radium for the department of surgery.

Episcopal Hospital, Philadelphia, $30,000 by the will of Mrs. Annie B. Moore.

Chestnut Hill Hospital, Philadelphia, $10,000, and Episcopal Hospital of Philadelphia, $5,000 by the will of Dr. William T. Van Pelt.

Misericordia Hospital, Philadelphia, $1,000 by the will of Mrs. Katherine L. Farrell.

Pennsylvania Hospital, Philadelphia; Allegheny General Hospital, Pittsburgh; Trudeau Sanatorium, Trudeau, N. Y.; one fourth each of the income from an estate of $822,160 left in trust by Mrs. Lillie Ingham Baker in 1931. The remaining fourth is to be distributed to various hospitals at the discretion of the trustees to help defray expenses of persons desiring the use of private rooms but unable to afford the entire charge.

St. Luke's and Children's Hospital, Philadelphia, $9,400 by the will of Miss Lucy L. Haswell.

Medical Bills in Congress.—*Changes in Status:* S. 5, the Copeland food, drugs, devices and cosmetics bill, failed to become a law. The bill, as amended by the House Committee on Interstate and Foreign Commerce, passed the House Friday, June 19, and was sent to conference. Subsequently, however, the Senate accepted the House amendments to the bill, subject to a new Senate amendment. The bill then again was brought before the House for consideration. The Senate amendment was defeated in the House and the bill died when the Congress adjourned, sine die, June 20. S. 4390 passed the House and Senate, providing that appointments to the Medical Administrative Corps shall be restricted to pharmacists who are graduates of recognized schools of pharmacy and requiring four years of instruction for graduation, and providing that the number of such pharmacists in the corps shall not exceed sixteen.

FOREIGN

Society News.—Those who wish to attend the third International Congress of Orthopedic Surgery in Bologna, September 21-25, may benefit from reductions in transportation costs if they register with the general secretary, Dr. Delchef, in Brussels, Belgium, before July 15, according to an announcement. Dr. Fred H. Albee, New York, is a vice president of the congress.

Personal.—Mme. Irene Joliot Curie, daughter of the discoverers of radium, has been named undersecretary for scientific research in the recently organized cabinet of the French government. Madame Joliot Curie, who from her childhood collaborated with the late Madame Curie in her research, shared the Nobel Prize in medicine in 1935 with her husband, Frederic Joliot, for their work on radium.

International Medical Week in Switzerland.—The *Swiss Journal of Medicine* will sponsor the second "International Medical Week" at Lucerne August 31-September 5. Among the lecturers on the provisional program are Drs. John F. Fulton, New Haven, Conn.; E. von Gröer, Lwow, Poland; Wolfgang Heubner, Berlin; Edward Mellanby, London; François Rathery, Paris; Ferdinand Sauerbruch, Berlin, and Albert Szent-Györgyi, Szeged, Hungary. The final program and other information may be obtained from the secretary, International Medical Week, Klosterberg 27, Basle.

Jubilee Book in Honor of Dr. Lambotte.—Friends, pupils and patients of Dr. Albin Lambotte, chief surgeon of the Stuiwenberg Hospital, Antwerp, Belgium, have arranged to publish a jubilee book in his honor. It is planned that the book will contain the history of the development of surgery of the bones and joints, to which Dr. Lambotte has contributed notably, outlined in articles by leading orthopedic surgeons from all parts of the world. It will appear in two volumes, according to an announcement. Subscriptions may be addressed to Dr. Jean Verbrugge, 75 Avenue Van Ryswick, Anvers, Belgium. The price of foreign subscriptions is 30 Belgian francs.

Government Services

Dr. Hall Named Chief of Zoology Division

Maurice C. Hall, Ph.D., since 1925 chief of the zoological division of the bureau of animal industry of the U. S. Department of Agriculture, has been transferred to a similar position at the National Institute of Health. Three of his associates in the bureau of animal industry, Eloise B. Cram, Ph.D., Myrna F. Jones, Ph.D., and John Bozicevich, A.M., will accompany Dr. Hall to the National Institute of Health. Dr. Hall received his degree of doctor of philosophy at George Washington University in 1915. He is 55 years of age. Benjamin Schwartz will succeed Dr. Hall at the bureau of animal industry.

Examination for Army Medical Corps

The War Department announces an examination during the week of August 24 to qualify candidates for appointment as first lieutenants in the Medical Corps, U. S. Army, to fill vacancies to occur during the fiscal year 1937. The examination is open to all male graduates of recognized medical schools who have completed one year's internship in an approved hospital and who will not be over 32 years old at the time it will be possible to tender a commission. Boards of experienced medical officers will conduct the examinations, which will consist of a physical examination, a written examination in professional subjects and a determination of the candidates' adaptability for military service. Full information and application blanks will be furnished by the War Department on request addressed to the adjutant general. Applications will not be considered after August 10. About thirty-five vacancies will occur during the year, and in addition an increase of fifty officers has been provided for in the War Department Appropriation Act.

Foreign Letters

LONDON

(From Our Regular Correspondent)

May 9, 1936.

A Bureau of Human Heredity

Some well known men, including Lord Moynihan, Sir Arthur Keith, Sir Grafton Elliot-Smith, Sir E. Gowland Hopkins and Sir Humphry Rolleston, have formed a committee to obtain support for the Bureau of Human Heredity, which was recently set up in London. In a joint letter to the *Times* they ask for $50,000 to carry on the work for five years. They point out that problems of national health have reached a point at which the hereditary element can no longer be neglected. Medical leaders are no longer satisfied with the alleviation of disease but feel the need of fuller knowledge of heredity in connection with prevention. This applies not only to preventing the transmission of defects. It is recognized that methods of cure must vary with the type of constitution of the patient, and here information as to heredity is important. In education, in training and in choice of a career the ascertainment of innate endowments is useful. The Imperial Bureau of Plant Genetics at Cambridge and of Animal Genetics at Edinburgh have achieved much by setting up simple machinery for collecting information based on the result of research and making these available for the practical breeder. The Bureau of Human Heredity will follow these models. The signatories say that in these days of international mistrust and animosity it is refreshing to find a field in which representatives of nearly every civilized country are engaged in cooperative work. A scheme for an international clearing house of facts concerning human heredity has been evolved by a small international committee, which has delegated to its British members the task of setting up a bureau in London for the collection and distribution of all authentic information on human genetics. The signatories point out how strange it is that students of fruit flies or mice have at their command the latest information, while those similarly concerned with man can look nowhere for a complete survey of the knowledge they require.

The Problem of Race

At the Royal Institute Mr. Julian Huxley gave an address on "The Race Problem" in which he showed the difficulties surrounding the use of the term race as applied to man and the misuse to which it is put by politicians and others. It was obvious that the different geographic groups of the human species differed inherently from one another. The term race had usually been used to denote such distinguishable groups, but difficulties arose. In the first place, characteristics that had no genetic basis but were national, cultural and linguistic had been erroneously ascribed to race. For example, there cannot exist such a thing as an Aryan race, since the term concerns language. Again, the main obvious differences between, say, the English, the French and the Germans, are not genetic but of national and cultural origin. In the second place, modern genetics has shown that after a cross all possible combinations of the genes concerned will be produced and will then continue to recur. In the absence of selection, no even approximately uniform blend will be formed. In the third place, man is so mobile that migration and intercrossing between different groups have been occurring on a large scale since before the dawn of history. Hence nothing approximating to a pure race now exists, with the possible exception of a few remote and primitive tribes. At best, race may be legitimately used of the hypothetical major groups (black, white and yellow) into which it has been deduced that our species early became differentiated and which may be called primary races, and of the equally hypothetical subgroups apparently produced by later differentiation of the white race into Mediterranean, Nordic and Alpine, which may be called secondary races.

At the present day there exists no important group which can properly be called a race, and the use of the term not only has no useful application but leads to confusion, both scientific and political. For groups of people genetically distinguishable from other groups, Mr. Huxley would use some noncommital term, such as ethnic group or ethnos. He holds that to define race in man is scientifically impossible, since the implications of the term do not correspond with reality. As the word race has been widely used in pseudoscientific ways to justify and rationalize various political and nationalist activities, he considers it highly desirable that some international inquiry should be made which would result in an impartial scientific pronouncement on the subject.

The Income Tax and the Birth Rate

The new taxes of the budget not only increase the rate payable on income but also increase the allowance made for dependent children. The result is that, while the unmarried and other payers of income taxes who do not have children dependent on them will be more highly taxed, 80 per cent of those with dependent children will gain. The object is no doubt to place the greater burdens on those best able to bear them, but it might be regarded as an attempt to encourage parenthood at a time when the birth rate has been reduced to a level which means a declining population. However, the amount of tax escaped by parenthood is too small for any perceptible effect. Moreover, the declining birth rate affects all classes, even those below the income tax level. It does not seem likely that the government had any such intention in view. Encouragement of the birth rate for militaristic reasons has been adopted as a deliberate policy in some continental countries, and recently by Russia, but it has never been as much as suggested in England and would certainly be scouted by most people. In a letter to the *Times*, Mr. R. A. Fisher, Galton professor of eugenics at University College, London, points out that, while the birth rate of England is now only three fourths of that necessary to maintain the population, no reasonable estimate would place the fertility of married payers of the income tax as high as two thirds of that of the general population. Thus their rate is not half that required for replacement. They bear the economic burden of rearing and educating children as well as part of that of the working class. The general decrease of the population of this country, which is now imminent, will entail economic consequences that have not received adequate attention.

The Official Grading of Milk

The minister of health has issued a new milk order to improve and simplify the special designations of milk. The present designations are "certified," "grade A (tuberculin tested)," "grade A" and "pasteurized." So many grades have been found to create confusion and some of the designations do not give consumers a clear indication of the nature of the milk purchased. The number of grades is to be reduced to three: "tuberculin tested," "accredited" and "pasteurized." "Tuberculin tested" replaces the existing "certified" and "grade A (tuberculin tested)," which both come from herds subjected to a stringent test for the absence of tuberculosis. "Tuberculin tested" will in future be the only designation. This milk may, if desired, be pasteurized, when it must be sold as "tuberculin tested milk (pasteurized)." It will then have the double security of tuberculin testing (as a safeguard against bovine tuberculosis and pasteurization as a safeguard against all milk-borne diseases). "Tuberculin tested milk" will be subjected to tests for ensuring cleanliness and good keeping qualities, but, because

of the need for simplification, the specially stringent bacteriologic test applied to "certified milk" is not retained. The other characteristic of "certified milk" was that it had to be bottled on the farm. When this is done the designation "tuberculin tested milk (certified)" will be permitted.

"Accredited milk" will be subject broadly to the same conditions as the former "grade A"; i. e., it will be raw milk from cows regularly inspected by a veterinary surgeon but not tuberculin tested. It will be subjected to the same bacteriologic tests as "tuberculin tested." The designation will indicate that it comes from herds of producers enrolled under the accredited producers' scheme, of which there are now nearly 16,000. When it is bottled on the farm, "farm bottled" may be added. "Pasteurized milk" will be, as at present, milk that has been held at a temperature of 145 F. for thirty minutes.

The present method of prescribing the bacteriologic standard by a plate count test of 200,000 bacteria per cubic centimeter will be superseded by a color test recommended by the Medical Research Council, but the test for coliform bacilli will be retained.

Radiology in the Medical Curriculum

A committee of the Royal Society of Medicine has made an important report on the place of radium in the medical curriculum. The teaching of radiologic anatomy and attendance on lecture courses in radiology and at the x-ray department are now required only in certain medical schools. The committee has made the following recommendations: Instruction in the physics of radiation should be given in the preclinical period. Radiology should be used when practical in the teaching of anatomy, physiology and pathology. Instruction in the use of x-rays in diagnosis and of x-rays and radium in treatment should be required in the clinical period of the curriculum. This may be accomplished: 1. By combined teaching by the clinician and radiologist. 2. By the radiologist conducting demonstrations in the x-ray department on selected films. Physicians and surgeons should attend these demonstrations and take part in the discussions. 3. By including lecture demonstrations by a radiologist in the course of lectures on medicine and surgery. 4. By forming an exhibition of roentgenograms illustrating clinical cases. The scheme to be adopted is left to the individual schools, but a combination of 1 or 2 with 3 and 4 is considered most satisfactory.

The Etiology of Phlyctenular Keratitis

At the Ophthalmological Society Arnold Sorsby, Richard Hamburger and R. L. Benham communicated an important paper on the vexed question of the etiology of phlyctenular keratitis. Their researches on a large scale at the White Oak Hospital, Swanley, show a positive Mantoux reaction in 80 per cent of cases. They also made an exhaustive survey of the literature. They conclude that the phlycten is a nonspecific reaction of the conjunctiva and conjunctival layer of the cornea—probably of anaphylactic nature. In something like 75 per cent of cases the state underlying the reaction is a tuberculous infection that occurs at an earlier age than in the normal child population. As in the latter, the infection is overcome in the great majority of cases. Because they are infected with tuberculosis earlier in life, phlyctenular cases give a greater quota of tuberculous disease than normal children. (The course of tuberculosis depends much on the age at which the patient is infected.) In a series of 238 cases followed from five to ten years, the subsequent incidence of tuberculous disease was ten times the notification rate for children of the corresponding age groups. The authors conclude that phlyctenular keratitis is not a manifestation of tuberculous disease but of tuberculous infection. Other factors than tuberculous infection can produce the phlyctenular reaction.

PARIS

(From Our Regular Correspondent)

May 8, 1936.

Danger of Vaccination Against Brucellosis with Living Vaccines

At the April 7 meeting of the Académie de médecine of Paris, veterinarians Velu and Zottner called attention to the fact that the use of living vaccines rendered the diagnosis of brucellosis in animals very difficult. Another contribution to the subject was presented at the April 21 meeting of the same society by Merliac and Lisbonne under the title "A Case of Undulant Fever of Bovine Origin: Danger for Human Beings of Animal Premunition with Living Vaccines." A woman, aged 52, wife of a farmer, complained in September 1935 of headache and lumbago, which had not improved after ordinary treatment. The only objective finding was a persistent rise of temperature (100-102 F.) accompanied by profuse sweats. The Widal test for typhoid was negative when the patient was first seen two months after the onset, but the blood showed a positive Wright reaction in a dilution of 1 to 250; hence the suspicion of an undulant fever was confirmed. Bacilli showing the typical reactions of Brucella abortus-bovis were found November 18 in the blood culture. After a prolonged febrile period the patient was considered as cured at the time the paper was read. Careful inquiry elicited the fact that no other cases of brucellosis had been reported from the section of country in which the patient had lived for many years.

A guinea-pig was inoculated with the milk of a cow which the patient had taken care of. Cultures of the blood of the guinea-pig also revealed the presence of Brucella abortus-bovis. The bacilli isolated from the patient's blood and that of the guinea-pig were found to possess identical properties (ability to produce hydrogen sulfide. The cow had been kept isolated from all other animals and had never aborted, wherefore the question arose as to how the brucella infection had occurred. On inquiry it was found that the cow had been given two prophylactic (premunition) injections of living brucella vaccines in 1933. Specimens of this vaccine were also found to possess the same property, which is atypical for Brucella abortus-bovis to produce hydrogen sulfide. Thus the three mediums (blood of patient, that of guinea-pig and the vaccine) possessed identical properties and the chain of evidence seems to be complete that the living vaccine infected the cow and, in turn, the patient.

At the 1934 congress of hygiene one of the authors, Lisbonne, as also Taylor and Vidal, called attention to the fact that undulant fever had been contracted by veterinary surgeons who had been accidentally inoculated by living vaccines; therefore the use of these in the prevention of "epizootic abortion" ought to be carefully controlled. The case reported by Merliac and Lisbonne shows that a living vaccine can be harmful not only by direct inoculation but by an intermediary, such as an infected animal.

Much care should be employed in selecting strains of bacilli for use as living vaccine. Only those which a number of experiments have shown to be attenuated should be used. Such a research is not easily accomplished. The use of living vaccines, at least in France, is not subject to the control which it merits. The indirect danger to human beings, as illustrated by this case, is one that cannot be minimized.

Acute Endocarditis Due to Bacillus of Pfeiffer

At the meeting of the Société médicale des hôpitaux of Paris, April 3, Lesne and his associates added another case of severe generalized infection, with an endocardial origin, due to the bacillus of Pfeiffer. A girl, aged 15 years, had been taken suddenly ill six days before admission to the hospital. At the onset, following emesis, a chill was noted followed by high temperature, which persisted without chills but was accom-

panied once by epistaxis. Soon after admission, the clinical picture appeared to be that of an endocarditis of probable rheumatic origin. A splenomegaly was noted. Three blood cultures were negative. About three weeks after admission, the clinical picture became that of acute septicemia, with recurrent chills, sweats and high temperatures and symptoms like those of a splenic infarct. Hemocultures during these three weeks revealed on two occasions the presence of a filament-like gram-negative bacillus, which was identified by Legroux of the Pasteur Institute as the bacillus of Pfeiffer. Symptoms of an acute nephritis appeared toward the end of the fourth week following the recurrence of chills and the girl died with the symptoms of a uremic coma.

The bacillus of Pfeiffer found in the blood was very difficult to reinoculate on culture mediums, but this was finally accomplished.

Compulsory Antidiphtheria Vaccination

At the same meeting Poulain quoted from the statistics of a large city, St. Etienne, in Central France on the value of prophylactic vaccination with the Ramon antitoxin in preventing the spread of diphtheria. An epidemic occurred in one of the suburbs, which involved from 8 to 10 per cent of the school children. The epidemic did not extend to St. Etienne, but nevertheless there were a number of cases in the city itself. Thirteen of these occurred in 1,000 nonimmunized children while one case was observed among 5,000 who had been vaccinated. Faced with the danger of extension of the disease and the fact that from 15 to 20 per cent of the children had not been vaccinated, an appeal was made to all parents to have all children immunized who had not received the anatoxin and to have all those already vaccinated subjected to another vaccination. This campaign was successful beyond all expectations, resulting in from 90 to 95 per cent of all school children now being vaccinated. From 60 to 70 per cent of these have received ninety anatoxic units.

Observations during the past seven years at St. Etienne have permitted the following conclusions:

1. A proportion of 80 per cent vaccinated children is sufficient to prevent a widespread extension of an epidemic but permits small centers of infection to exist which become a serious menace if there is a decrease in the number of vaccinated children.

2. To keep up a high percentage of vaccinated children a constant propaganda to secure written permission of the parents is essential.

3. In vaccinations consisting of only two injections occasional but benign cases persist.

To cause diphtheria to disappear completely, antidiphtheria vaccination should be made obligatory, at least in cities, before admission to schools. A second vaccination should be given one or two years later.

Coagulation of the Blood

At the Dec. 11, 1935, meeting of the Société française d'hématologie, Nolf of Brussels stated that in spite of numerous efforts made to explain the physiology of coagulation the causes still may remain obscure. The theories generally accepted are far from being proved, so that much confusion still exists. Does the plasma contain all the elements essential to the formation of fibrin and thrombin or is the plasma in a pure state, according to the classic theory, noncoagulable because it lacks an essential element which the leukocytes and blood platelets furnish? Antithrombin is elaborated in the liver. Antithrombin disappears during coagulation and it is this digestion or consumption of the antithrombin which is the first stage of coagulation. The thrombin is said to be a product of a substance termed prethrombin, but Nolf does not believe that thrombin should be applied to a definite chemical entity; rather one must apply the term thrombin to an ensemble of nonsaturated complexes of fibrinogen which appear during the act of coalescence of colloidal particles, termed coagulation of the plasma. Thrombin is not the result of the transformation of a single substance, prothrombin, but is formed by the union of two protein constituents of the plasma, the thrombozyme and the thrombogen.

The recent work of Gengou on the coagulating action of staphylococci on the plasma amply confirms Nolf's views. The intervention of fibrinogen favors the union of thrombozyme and thrombogen and in very stable liquids permits formation of thrombin. This permits the abandonment of the classic theory of coagulation occurring in two steps and its replacement with a one step process. Fischer in his studies on coagulation in birds has shown that the formation of fibrin does not await the moment when all the necessary thrombin has been formed but begins immediately.

Nolf maintained that coagulation seems essentially to be an autocatalysis.

Prophylaxis of Contagious Diseases in France

The chairman, Professor Lemierre, of the Special Committee of the Academy of Medicine, gave the report for 1934. Typhoid existed in practically every department (county) of France, in isolated cases or in epidemics that were sharply localized. Some ascribe the recrudescence of the disease to the drought which existed during the greater part of 1934, so that people were obliged to seek water far from their homes at polluted sources. The ingestion of clams at seaside resorts was responsible for a large number of cases. In spite of warnings and legal procedures, the shores from which shellfish of all kinds are obtained continue to be found too near the outlet of sewers. This is especially true of Toulon, the principal French naval base. Vaccination has greatly diminished the incidence of typhoid, but unless made compulsory, as in the case of those entering military or naval service, its prophylactic value is ignored by the average citizen.

Variola is practically nonexistent in France. Occasionally, cases are found, as recently at Reims, in those coming from other parts of Europe. The benefits of vaccination are well illustrated by the diminution of variola in Algiers, a large French colony. In 1927, 4,000 cases of variola were reported, whereas in 1934 there were only nineteen cases.

Measles is perhaps the most common of all the contagious diseases in France.

The incidence of diphtheria has been greatly lessened as the result of an organized campaign to use the Ramon anatoxin as a vaccine. Some cases of diphtheria occurred in vaccinated children. This emphasizes the necessity of revaccination if the Schick reaction remains positive. This was the case in 1934, in 40 per cent of 250 children who had been given three injections of the anatoxin in 1933.

Isolated cases of cerebrospinal meningitis were reported from fifty-four of eighty-eight departments. The search for carriers always resulted negatively; hence prophylactic measures are impossible at present. The mortality was very high, 47 per cent of eighty-five reported cases, despite early specific treatment.

Isolated cases of poliomyelitis were reported from fifty-seven of eighty-eight departments. There were seventy-one cases with twenty-two deaths in the Paris region. No progress was made in clearing up the manner in which the infection spreads.

There was ample evidence of an increase in the incidence of undulant fever. It was reported from forty-two of eighty-eight departments, located in all parts of France. Brucella melitensis was responsible for practically every case. The atrium of infection was most frequently through skin abrasions, less so as the result of drinking unboiled milk or of eating fresh cheese. Brucellosis in human beings and in animals are closely allied,

although due to different types of the Brucella organisms. Efforts are being made to immunize those whose occupations bring them into contact with animals who are carriers or are infected by organisms of the Brucella type.

BERLIN

(From Our Regular Correspondent)

April 29, 1936.

The Sick Insurance Societies During 1934 and 1935

The final figures on the work of the sick insurance societies during the years 1934 and 1935 have been made available. The number of such organizations tends to decrease as the result of mergers of the smaller societies. In 1914 sick insurance societies in the German reich numbered more than 10,000; in 1934 there were barely 6,000. The total membership in 1934 amounted to nearly 20,000,000 persons, of whom 13,000,000 were males. The number of cases in which the societies according to statute became liable for payment of claims increased from 35,000,000 in 1932 to 46,400,000 in 1934. The insured himself received the benefit in 31,700,000 of the cases for 1934, and relatives of the insured in 14,700,000 cases. Two factors are responsible for the increased morbidity: 1. Persons who had been unemployed for a long time were not equal to exacting occupational requirements and hence were more susceptible to illness. 2. Many persons, fearful of losing their jobs if they reported sick, failed to report. The danger of these eventualities has lessened with the improvement in the labor market. This improvement has also brought about an increase in the number of insurance holders even among the upper age groups. In 1934, 6,800,000 cases of illness led to temporary working disability; in 1933 there were 5,400,000 such cases. On the other hand, the average duration of illness declined from 29.3 days in 1932 to 24.6 days in 1934.

The number of cases in which obstetric care was paid for increased about 32.7 per cent, from 574,515 cases in 1933 to 762,428 in 1934. The number of fatalities rose from 137,670 to 146,191, because of an increase in the number of older workers employed.

Both income and expenditures of the sick insurance societies increased during 1934. Gross income amounted to nearly 1,300,000,000 reichsmarks, or 62.10 reichsmarks per member. Disbursements increased from 1,181,000,000 reichsmarks to 1,314,000,000 reichsmarks; that is, an increase per member of from 63.69 to 65.89 reichsmarks.

TABLE 1.—*Type of Assistance in Sick Aids*

Type of Aid	Amount Expended in Reichsmarks
Medical treatment	330,683,000
Dental treatment	98,163,000
Medicaments and therapeutic accessories	158,976,000
Hospital care	224,548,000
Sick benefits in cash	224,121,000

TABLE 2.—*Average Amount per Member Expended by Sick Insurance Societies*

Year	Amount	Year	Amount
1929	20.86 RM	1932	16.50 RM
1930	20.66	1933	16.26
1931	18.61	1934	16.57

TABLE 3.—*Disbursements According to Type of Organization*

Class of Insurance Organizations	Total Expenditure for Doctor's Fees in Reichsmarks	Total Membership	Expenditure per Member in Reichsmarks
Municipal	179,462,000	12,124,000	14.80
Rural	20,732,000	1,802,000	11.50
Industrial	54,734,000	3,002,000	18.25
Guild (innung)	7,738,000	529,000	14.63
Miners	10,605,000	564,000	18.80
Supplementary (ersatz)	56,547,000	1,878,000	30.11

TABLE 4.—*Expenditures per Member*

	Reichsmarks
Treatment by approved physicians	15.37
Dental treatment	4.68
Medicaments and other therapeutic adjuncts	8.08
Hospital care	11.67

The sum of 1,055,000,000 reichsmarks was expended for sick aids; its distribution according to type of assistance is given in table 1.

All the sick insurance societies (including the ersatz, or supplementary societies) expended the average amounts per member from 1929 to 1934 given in table 2.

The amount disbursed in physicians' honorariums differed considerably according to the type of organization, as table 3 illustrates.

TABLE 5.—*Increase in Disbursements from 1933 to 1934*

Medical treatment	2.0 per cent
Dental treatment	8.8 per cent
Medicaments and so on	9.6 per cent
Hospital care	1.6 per cent

For obstetric care, 122.40 reichsmarks per member was expended; for death claims 84.77 per insured person. Administrative costs amounted to 135,100,000 reichsmarks.

Unencumbered assets of the organizations, despite a decrease of some 17,900,000 reichsmarks, still totaled 818,700,000 reichsmarks. Reserve funds decreased by around 35,500,000 reichsmarks; they were however, with 402,300,000 reichsmarks, double the amount stipulated by law.

TABLE 6.—*Income of Members in Billions of Reichsmarks*

1929	31.6	1933	18.5
1930	29.5	1934	21.1
1931	24.0	1935	22.2
1932	18.5		

According to official monthly reports, the number of insurance societies was considerably decreased during 1935. On Jan. 1, 1936, there were barely 5,000 such organizations, as against more than 21,000 in 1913.

The total membership amounted to around 20,800,000 on Oct. 31, 1935, against 17,800,000 at the beginning of 1933. Cases of illness involving impaired working capacity increased in number from 7,400,000 in 1934 to 8,000,000 in 1935. This was due to the factors that have been adduced. The influenza patients are also included in the 1935 total.

Total expenditures (1,272,600 reichsmarks) exceeded the total income by around 57,600,000 reichsmarks. The per member expenditures in 1935 by the legally authorized societies are given in table 4.

Expenditures for these services increased in varying degree: for medicaments the increase was 9.3 per cent; for dental treatment, 5.2 per cent; for hospital care, 3.5 per cent, and for medical treatment, 1.3 per cent.

Disbursements for the same purposes increased from 1933 to 1934 as in table 5.

It will be noted that the cost of treatment by approved physicians showed a modest increase from 1933 to 1935.

The personal administrative costs increased 3.2 per cent per member, the material costs 5 per cent per member. Gross income increased around 4.5 per cent. The National Bureau

TABLE 7.—*Fluctuations of Average Income*

1929.....	1,508 RM	1933.....	1,099 RM
1930.....	1,452 RM	1934.....	1,165 RM
1931.....	1,263 RM	1935.....	1,180 RM
1932.....	1,083 RM		

of Statistics attributes this to an increase in the incomes of members. In table 6 the total income of all the members from 1929 to 1935 is given in billions of reichsmarks.

The average income per member showed the fluctuation given in table 7.

ITALY

(From Our Regular Correspondent)

April 15, 1936.

Some Problems of Physicians

The first reunion of the Corporazione delle professioni e delle arti was recently held in Rome under chairmanship of the head of the government. The vice president of the corporation observed that the free activities of the medical profession come to a standstill whenever new institutions of the nature of the Casse Mutue Sanitarie (centers for medical care of insured workers) are opened. He stated that in order to protect medical practice it is necessary to review the plans of the several branches of medicine, to establish restricted and special functions for each different branch and to make compulsory the registration of practitioners in the book for that purpose. The new national medical fees were discussed. The National Syndicate of Physicians suggested a plan of fees in which there is a tendency to standardize the fees of the several provinces and to fix a minimal fee without indicating the maximal charges, excluding from the fee the medical attendance given by specialists, regular professors and university professors. The following are the charges proposed: visits for consultation and care of the patient at his own home, 20 lire ($1) if it is only one visit and 15 lire ($0.75) if there are several consecutive visits. The charges for visits for consultation and care of the patient at the physician's office will be 15 lire ($0.75) for only one visit and 10 lire ($0.50) for several consecutive visits. Consultations in emergencies will be charged with 25 lire ($1.25) if during the day and 40 lire ($2) if during the night.

Influenza and Tuberculosis

The Federazione per la lotta contro la tubercolosi recently discussed the influence of influenza on development of tuberculosis. Professor Ramoino stated that influenza prepares the terrain for the development of common chronic catarrh, which predisposes the organism of the patient to the development of tuberculosis.

Professor Manara emphasized the importance of establishing, with precision, the clinical picture of sporadic influenza in order to differentiate these types of influenza from tuberculosis when the latter follows an atypical evolution.

Professor Maragliano has seen a large number of cases of pulmonary tuberculosis, in more than half of which the evolution of the disease was related to an attack of influenza. As a rule the postinfluenzal symptoms are so trivial that they are not noticed. There is slow but progressive loss of weight, slight fever in the evenings, weakness, and incapacity for physical and mental work. Cough and other symptoms which erroneously have been considered as early symptoms of pulmonary tuberculosis are absent. If the patients are seen early in the development of the disease, both clinical and roentgen examinations fail to prove the presence of tuberculosis. Early diagnosis is possible, however, in this type of pulmonary tuberculosis by estimating the symptoms given by the tuberculous toxemia, the evaluation of which is of importance in controlling further development of the disease.

Selection of Physicians by Insured Workers

An agreement was recently made for the medical and surgical care of insured workers in the Casse Mutue dei lavoratori de l'industria. As a rule the consultations and treatment of the patients will be made in the clinics for ambulatory patients, except in cases in which the patients are in such a condition as to be unable to go to the ambulatory clinic. In the latter event the patients will be seen and treated at home. Insured workers are free to select their own physicians, either from those of the group of municipal physicians or from those who have a private clientele; but after having chosen a physician they cannot change to another during an illness. Physicians who practice in connection with the insurance societies will be registered in a special provincial book of registration. Enforcement of the standards established in the agreement will be in the hands of a committee.

Surgical Society Meeting

Professor Finsterer of Vienna spoke on surgery of the large intestine recently before the Società Piemontese di chirurgia. Surgical indications in constipation are restricted to grave cases after failure of diet and medical treatments if cathartics administered cause intense pain to the patient. The speaker never resorted to the performance of anastomosis in treating either spastic constipation or megacolon. In some grave cases of spastic constipation, simple distention of the anal sphincter, either hypertrophic or with anal fissure, has resulted in cure with regression of a marked dilatation of the sigmoid flexure of the colon. The anal sphincter should be investigated before a decision is made to perform any operation in cases of constipation. Resection of the sigmoid flexure is indicated in megasigmoid in cases in which the formation of valves in the flexure are the main cause of constipation. The speaker, in performing hemicolectomy, removes the half of the colon up to the pelvic colon. The elimination of general anesthesia for the operation and the use of laterolateral anastomosis are the factors that account for the satisfactory results obtained.

Professor Uffreduzzi spoke on postanastomotic peptic ulcer. The nature of the postanastomotic scar is related to the constitution of the patient. Innervation disturbances with paralysis of the anastomotic loop or with spasms of either the afferent or the efferent loops may take place in the new formed pylorus. Frequently these disturbances are caused by the presence of a peptic ulcer located at either the gastric or the jejunal anastomotic ends or in the jejunum at a certain distance from the anastomosis. Postanastomotic peptic ulcers may follow a long evolution without grave complications. Surgery is the only indicated treatment. The speaker classified his patients in seven groups according to the type of operation performed.

Marriages

HENNING W. MATHIASEN, Persia, Iowa, to Miss Rita Rose Dougherty of Manilla in Des Moines, May 25.

DONALD MUNRO MACINTOSH JR., Old Fort, N. C., to Miss Ruth Ellen Gish of Philadelphia, May 6.

CARL D. OELRICH, Sioux Center, Iowa, to Miss Thelma Mae Austin of Albany, Mo., May 15.

JOEL ERNEST GOLDTHWAIT to Mrs. Phillip Leverett Saltonstall, both of Boston, April 30.

CARL V. MORRISON, Grinnell, Iowa, to Miss Dorothy Nafus of Nashua, April 25.

Deaths

James Tate Mason ✠ Seattle, President of the American Medical Association, died, June 20, at the Virginia Mason Hospital, of endocarditis with multiple emboli, aged 54. Dr. Mason was born in Virginia, May 20, 1882, the son of Dr. Claiborne Rice Mason of Lahore, Orange County, Va. After graduating from the University of Virginia Department of Medicine, Charlottesville, in 1905, Dr. Mason engaged in the practice of surgery first at Philadelphia, then at Franklin, Wash., and finally at Seattle, where he had practiced continuously since 1909. From 1916 to 1920 he was surgeon and superintendent of the King County Hospital. Since 1920 he had been chief surgeon to the Mason Clinic and president of the Virginia Mason Hospital. He was consulting surgeon of the United States Marine Hospital, Seattle, the American Mail Line, the Alaskan Steamship Company and the Northern Pacific Railroad Company. Dr. Mason was a member of the House of Delegates of the American Medical Association for six years, between 1928 and 1934; he was secretary of the Section on Surgery, General and Abdominal, from 1923 to 1926, when he was elected chairman, serving in that capacity for one year. Dr. Mason was past president of the Pacific Coast Surgical Association, and in 1930 vice president of the American Association for the Study of Goiter; a member of the American Surgical Association, Southern Surgical Association, Western Surgical Association, and the North Pacific Surgical Association, and fellow of the American College of Surgeons. He was at one time a county coroner and a member of the state board of health.

JAMES TATE MASON, M.D., 1882-1936

Tate Mason was a genial, friendly man, much beloved by all who knew him. He was a builder, a true leader. During his term as President-Elect he traveled widely on behalf of the Association, notwithstanding ill health and the pressure of his own affairs. During the Kansas City session, although imminently confronted by impending death, he kept in intimate touch with the progress of affairs, made the necessary appointments and urged the promotion of high standards and high ideals. By his death, American medicine loses a leader, chosen for its highest honors, who demonstrated by his life and by his death how well he merited this recognition.

William Hemple Arthur ✠ Brigadier General, U. S. Army, retired, Washington, D. C.; University of Maryland School of Medicine, Baltimore, 1877; member of the House of Delegates of the American Medical Association in 1915; entered the army as an assistant surgeon in 1881; commander of a hospital ship during the Spanish-American War; served with the China Relief Expedition in 1900 and in the Philippines; in 1908 was promoted to lieutenant colonel and in 1911 colonel; appointed commandant of the Army Medical School in 1915; served during the World War; was retired as a brigadier general under the Act of June 21, 1930; fellow of the American College of Surgeons; formerly emeritus professor of military surgery, Georgetown University School of Medicine; at one time medical director of the Georgetown University Hospital; aged 80; died, April 19, in the Walter Reed General Hospital.

Henry Hawkins Tyson ✠ New York; University of the City of New York Medical Department, 1887; at one time instructor in ophthalmology, Columbia University College of Physicians and Surgeons; member of the American Ophthalmological Society; fellow of the American College of Surgeons; past president of the New York Ophthalmological Society; during the World War, eye examiner for the third district of the New York Draft Board; ophthalmic surgeon to the Herman Knapp Memorial Eye Hospital; ophthalmologist to the Sea Breeze Hospital, Brooklyn, and the Letchworth Village, Thiells; assistant in the eye department at the Vanderbilt Clinic; author of numerous monographs on ophthalmologic subjects; aged 70; died, April 18.

Edgar Warden Phillips ✠ Rochester, N. Y.; Cornell University Medical College, New York, 1911; assistant professor of surgery, University of Rochester School of Medicine; fellow of the American College of Surgeons; member of the American Association for Thoracic Surgery; attending surgeon to the Rochester General Hospital, surgeon to the Monroe County Tuberculosis Sanatorium and consulting surgeon to the Rochester State Hospital; aged 47; died, May 5, of lobar pneumonia.

William Clifton Lyle, Carrollton, Ga.; University of Georgia Medical Department, Augusta, 1893; member of the House of Delegates of the American Medical Association, 1911, 1914 and 1922; fellow of the American College of Surgeons; for many years secretary of the Medical Association of Georgia; formerly professor of otology at his alma mater; served during the World War; aged 64; died, April 15, of cardiovascular renal disease and arteriosclerosis.

George Whitfield Stephens ✠ Melrose, La.; Tulane University of Louisiana Medical Department, New Orleans, 1907; member of the New Mexico Medical Society and the American Psychiatric Association; served with the British Army during the World War; formerly superintendent of the New Mexico Home and Training School for Mental Defectives, Los Lunas; aged 57; died suddenly, April 26, in a hotel at New Orleans, of heart disease.

Wells Teachnor Sr. ✠ Columbus, Ohio; Medical College of Ohio, Cincinnati, 1892; member of the House of Delegates of the American Medical Association in 1924 and 1925 and from 1927 to 1936; past president of the Ohio State Medical Association; fellow of the American College of Surgeons; member of the staff of the Hawkes Hospital of Mount Carmel, now known as the Mount Carmel Hospital; aged 66; died, June 12.

Clarence Eugene Simonds, Willimantic, Conn.; University of the City of New York Medical Department, 1897; member of the Connecticut State Medical Society; fellow of the American College of Physicians; served during the World War; chief physician, obstetrician and president of the medical and surgical staff of the Windham Community Memorial Hospital; aged 62; died, April 1.

Robert James Marshall, East Liverpool, Ohio; Western Reserve University Medical Department, Cleveland, 1886; member of the Ohio State Medical Association; formerly mayor and member of the city council; on the staff of the East Liverpool City Hospital; aged 73; died, March 2, of cerebral hemorrhage.

Frank Lester Todd, Pittsburgh; Western Pennsylvania Medical College, Pittsburgh, 1891; member of the Medical Society of the State of Pennsylvania; fellow of the American College of Surgeons; member of the consulting staff of the Presbyterian and Allegheny General hospitals; aged 74; died, April 17, in the Conway (S. C.) Hospital, of pneumonia.

Henry Strauss Wieder ⊕ Philadelphia; University of Pennsylvania Department of Medicine, Philadelphia, 1902; associate professor of otology, University of Pennsylvania Graduate School of Medicine; on the staff of the Northern Liberties Hospital; aged 54; died, April 22, of fracture of the fibula and pulmonary embolism following a fall.

Charles Augustus Vosburgh ⊕ St. Louis; Barnes Medical College, St. Louis, 1904; member of the Radiological Society of North America; past president of St. Louis City Medical Society; served during the World War; formerly professor of clinical surgery and surgical pathology at his alma mater; aged 57; died, April 19, of heart disease.

Earl Roach McCarthy ⊕ Chicago; Rush Medical College, Chicago, 1922; fellow of the American College of Surgeons; formerly clinical instructor in surgery at his alma mater; aged 40; on the staffs of the Cook County Hospital and the Presbyterian Hospital, where he died, April 21, of malignant nephrosclerosis and uremia.

Harry Samuel Lane ⊕ Kansas City, Mo.; University Medical College of Kansas City, 1908; member of the Associated Anesthetists of the United States and Canada; medical director of the Fairmount Maternity Hospital; aged 60; was killed, April 14, in an automobile accident.

Russell Ellis Minter, Borger, Texas; Vanderbilt University School of Medicine, Nashville, Tenn., 1926; member of the State Medical Association of Texas; past president of the Hutchinson County Medical Society; aged 36; died, March 18, of agranulocytosis.

John Nevin ⊕ Jersey City, N. J.; University of the City of New York Medical Department, 1886; formerly medical director of the Jersey City Hospital; for many years police surgeon; aged 72; died, April 26, of cerebral hemorrhage.

Henry William Norrish, Logan, Kan.; Ensworth Medical College, St. Joseph, 1894; Missouri Medical College, St. Louis, 1895; member of the Kansas Medical Society; aged 66; died, March 15, of cardiovascular renal disease.

Louis Maddock, San Andreas, Calif.; Jefferson Medical College of Philadelphia, 1893; aged 67; died, March 25, in Stockton, of coronary occlusion, arteriosclerosis and injuries received when he fell down the stairs.

James Claude Woodward, Los Angeles; Lincoln (Neb.) Medical College of Cotner University, 1900; aged 58; died, March 30, of carcinoma of the parotid gland with metastases to the liver, spleen and kidneys.

Thomas Allen McCormick ⊕ St. Albans, Vt.; University of Vermont College of Medicine, Burlington, 1915; on the staff of St. Albans Hospital; aged 46; died, March 28, of a self-inflicted bullet wound.

Edith Lyall Maddren Mosher, Dupree, S. D.; National University Medical Department, Washington, D. C., 1899; aged 59; died, March 10, in Rapid City, of intestinal obstruction.

Simon Leo Wissig, Chicago; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1905; aged 62; died, March 21, of chronic myocarditis.

Albert Willis, Metropolis, Ill.; St. Louis College of Physicians and Surgeons, 1904; member of the Illinois State Medical Society; aged 54; died, March 6, of diabetes mellitus.

Andrew Jackson Morris, Newton, Ala.; Southern Medical College, Atlanta, Ga., 1887; member of the Medical Association of the State of Alabama; aged 73; died, March 15.

Charles Louis Marotte ⊕ Trenton, N. J.; Georgetown University School of Medicine, Washington, D. C., 1930; aged 31; died, March 17, in St. Francis Hospital.

Harold Everett Smiley, Providence, R. I.; Harvard University Medical School, Boston, 1922; pathologist to the Charles V. Chapin Hospital; aged 45; died, March 27.

Andrew Murphy Jr., Mohawk, N. Y.; University and Bellevue Hospital Medical College, New York, 1901; aged 58; died, March 15, of carcinoma of the rectum.

Robert T. A. Nixon, Brookfield, Wis.; Detroit College of Medicine, 1903; aged 57; was instantly killed, March 31, when his automobile was struck by a train.

Clifton Horace Frizelle, Chicago; College of Physicians and Surgeons, Keokuk, Iowa, 1889; aged 67; died, March 23, in Elgin, Ill., of arteriosclerosis.

Emett Lucien Siver, Chicago; Fort Wayne (Ind.) College of Medicine, 1884; aged 76; died, March 6, of carcinoma of the urinary bladder.

Henry P. Hart, Chicago; Rush Medical College, Chicago, 1891; aged 71; died, March 21, of chronic myocarditis.

Correspondence

INEFFICIENCY OF GARGLES

To the Editor:—In a communication published in THE JOURNAL, May 9, page 1679, Kaunitz criticizes—rightly, I think—the technic by which investigations of the efficacy of the "gargle" have been carried out. I fully agree with his conclusions.

Some ten years ago I investigated this question by having ten patients gargle with a solution of methylene blue after administration of atropine. An examination made immediately afterward showed that in no case had the fluid reached the tonsils, the posterior pharyngeal wall, the posterior part of the soft palate or the uvula. In most cases the dye stained only the anterior half of the soft palate. From this investigation I reached the conclusion that gargling was entirely useless as a method of introducing an antiseptic medication to the tonsil or pharynx.

H. M. WALKER, M.D.,
145 Harley Street, W. 1, London, England.

DIPHTHERIA WITH SCARLET FEVER

To the Editor:—In reading the communication of Dr. Alexander Zabin, in THE JOURNAL, May 2, page 1588, I was struck by his statement that "diphtheria coexistent with scarlet fever is about one in every ten thousand cases." I had always considered it far more common.

While it is true that diphtheria complicating scarlet fever is not frequent during the first or even the second week of the disease, being usually a complication of convalescence and as such being referred to usually as "postscarlatinal diphtheria," it is nevertheless a not uncommon complication at any stage. As a matter of fact, Schamberg and Kolmer state that in a series of 1,259 cases of scarlet fever in which routine throat cultures were taken before or after admission to the Philadelphia Hospital for Contagious Diseases 285, or 29.25 per cent, showed diphtheria-positive cultures. Certainly the coexistence of these two diseases cannot be regarded as a rare complication.

As for the statement that "the immunity conferred by toxin-antitoxin or toxoid is only relative and not absolute," it is of course known that cases of diphtheria have occurred in children with negative Schick tests, although there is always the possibility of an error in technic in performing the test.

SANDOR A. LEVINSOHN, M.D., Paterson, N. J.

TUBING FOR DRAINAGE OF THORACIC CAVITY

To the Editor:—In the Therapy of the Cook County Hospital (THE JOURNAL, May 16, p. 1728) I see that reference is made to the use of red rubber tubing in the drainage of spaces within the thorax, because it is opaque to x-rays and films can therefore be made for information and record.

The usual red rubber tubing, however, is too hard for safety in this part of the body, and for that matter in several other regions also. In the chest, which is in constant motion, the pressure and friction of a stiff tube has produced many serious complications; for example, hemorrhage, bronchial fistula extension of a suppurative process, and extension of infection to the mediastinum and its organs.

There is at least one form of red rubber tube which has not these disadvantages, but this is not radiopaque. A pro-

cedure which I think far preferable is to use tubes of soft, virgin gum, usually black, and when I wish to outline or otherwise observe the conditions within the drained cavity, I slip a small catheter or other opaque rubber tube through the drainage tube as far as may be necessary, and immediately after the x-ray exposure has been made it is withdrawn. This method is also preferable to the injection of opaque fluid into a drained cavity.

HOWARD LILIENTHAL, M.D., New York.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

DIETS FOR BOYS IN CAMPS

To the Editor:—A camp houses and feeds about 200 youngster between the ages of 17 and 28. The ration allowance is a shade less than 50 cents a day. On this money it is possible to feed satisfactorily as far as quality and tastiness are concerned. The quantity also is sufficient. However, in winter the ration allowance does not permit the buying of any considerable quantity of fresh vegetables or other kinds of "roughage" and, as a result, the boys often suffer from constipation. Canned fruits and vegetables are available but the cooks, although thoroughly experienced and well qualified, do not seem to have the knack of preparing these in a sufficiently palatable way to overcome the urge for "meat 'n spuds" on the part of the enrollees. Any suggestions you may make or any special cook book you may recommend will be greatly appreciated, I assure you. Would the limiting of the quantities of meat and potatoes on the table help sufficiently to warrant instituting the measure? Kindly omit name and address.

M.D., Michigan.

ANSWER.—Young men between the ages of 17 and 28 require a varied diet, including fruits and vegetables. The fresh vegetables may be served raw or in salads. The canned vegetables may be used in soups, scalloped dishes and stews or baked with cheese. Young men as a rule like cheese. The canned fruits may be served with cake or with puddings, such as cornstarch or tapioca pudding. Cornstarch pudding topped with canned berries such as loganberries, strawberries or raspberries is a very popular dessert. Dried fruits, such as raisins or dates, may be cooked in with the breakfast cereal.

The October 1935 issue of *Scouting,* the Boy Scout magazine, has some excellent suggestions for camp menus. "Large Quantity Cookery" by Richard and Trent (Boston, Little, Brown & Co.) has many interesting recipes.

SPINAL FLUID TEST FOR INFANTILE PARALYSIS

To the Editor:—In making a spinal fluid test for infantile paralysis, how is the test made? What does it show? How soon after exposure will it show? Is the test positive? What is the standard treatment at present? What is your opinion of the treatment of a young patient who was sick for three or four days? Paralysis developed, and a blood transfusion was given from the mother, who had never had infantile paralysis. No other treatment was given. About twelve hours later the patient was considered out of danger. Please omit name.

M.D., Washington.

ANSWER.—When spinal fluid is obtained by lumbar puncture, the degree of pressure and the clarity are observed. For proper interpretation there should be an absence of traumatic blood.

Further examination of the spinal fluid should include a cell count on a hemocytometer to determine the number of cells per cubic millimeter. A Pandy test for globulin should be made and also a Ross-Jones test for albumin. In addition, a quantitative test (modified Folin-Wu) for sugar, which should be normal in poliomyelitis. A differential cell count must be done.

In poliomyelitis, the spinal fluid is usually under increased pressure and its transparency is about the same as with normal fluid. Lymphocytes predominate, from 90 to 95 per cent often, except in the very early stage of the disease. The total number of cells should exceed 10 per cubic millimeter in any case of poliomyelitis. Abnormalities in the spinal fluid will not follow exposure of the patient to infantile paralysis unless the patient contracts the disease. When symptoms of infantile paralysis appear, the spinal fluid should show the customary signs.

The tests here described are regarded as reliable and confirmatory of clinical signs.

Usual treatment consists of absolute rest in bed, with spinal punctures for release of fluid as may be necessary to relieve intracranial pressure.

The intravenous administration of convalescent poliomyelitis serum (human) in quantities of from 50 to 100 cc. is sometimes advocated. There is also antistreptococcus poliomyelitis serum (horse) on the market.

A conclusion drawn from the case cited would be misleading. Was the patient ever in danger? Under some circumstances blood transfusions are beneficial in poliomyelitis as in other infections. Adult blood even in those without a history of infantile paralysis often contains neutralizing substances which are presumably helpful in treating poliomyelitis by transfusion.

REDUCTION OF GLARE IN OPHTHALMIC LENSES

To the Editor:—Kindly inform me whether there is any new type of glass being made for lens purposes which is designed to reduce glare, other than the usual soft light and other tinted lenses. Please omit name.

M.D., Wisconsin.

ANSWER.—Glare is defined as "a blinding sensation caused by excessive brightness of light in the field of vision, by extreme contrast between a light source and its surroundings or by continued exposure of the eye to a light source" (National Encyclopedia). With that definition in mind it is obvious that all that any glass can do in reducing glare is to reduce the total intensity of light. This is accomplished by the usual tinted lenses, regardless of the trade name, the amount of absorption depending on the depth of the tint. On the other hand, certain supposedly irritating rays of various spectral length can be eliminated by absorption, depending on the character of the glass used. Thus one type of glass will absorb all the ultraviolet rays and, if the glass is thick enough, much of the violet end of the spectrum. In this type fall the Noviol, Hallauer and such. Again, another type will absorb infra-red rays and some of the visible rays at the end of the spectrum, notably the Crookes glass. A third type of very recent origin absorbs a greater percentage of the yellow or sodium waves than any of the other visible rays of the spectrum. This is accomplished by incorporating neodymium in the glass.

TREATMENT OF SYPHILIS

To the Editor:—Would you please advise me what would be considered a satisfactory form of antisyphilitic treatment for the following classes of syphilitic patients: 1. Those with positive blood Wassermann and Kahn reactions in good physical condition. 2. Those with positive Wassermann, Kahn and spinal fluid reactions in good condition. 3. The foregoing in poor physical condition; i. e., those who are undernourished and weak or who have cardiovascular-renal complications. 4. Paretic individuals. 5. Senile patients with syphilis or those over 50 years of age. In each of these categories how long would you consider treatment necessary (*a*) provided there is improvement; (*b*) provided there is no improvement? Would the presence of a psychosis due to syphilis necessarily alter the treatment given? Is aqueous solution of bismuth a satisfactory intermuscular preparation? Please omit name.

M.D., Florida.

ANSWER.—1. In syphilitic patients with positive blood Wassermann and Kahn reactions, provided they are in good physical condition and show no involvement of the spinal fluid, Cooperative Clinical Group studies have shown that if continuous therapy is employed, alternating courses of neoarsphenamine, ten injections each, and intramuscular injections of a bismuth compound, ten each, for a series of three courses of each, followed perhaps for the next two years by two short courses of intramuscular injections of a bismuth compound a year, will take care of the patient nicely.

2. Syphilitic patients having a positive Wassermann and Kahn test and positive spinal fluid should probably undergo a course of malaria therapy, consisting of from ten to fifteen good chills, provided they stand it all right, after which the preceding therapy might be followed, using continuous, alternating courses of arsenicals and bismuth compounds for at least two years. What should be done after that will depend on the patient's condition and the laboratory examination.

3. Naturally, given a patient in poor physical condition, perhaps having cardiovascular renal complications, the situation is quite different. To be sure, it is difficult to know what is meant by cardiovascular renal complications. If the patient has cardiac syphilis the Cooperative Group, in a report about to be published, has shown that such patients should never have therapy started with an arsenical but should be treated

first with heavy metal for a period of at least three months, and at no time in cardiovascular syphilis should arsenicals in large doses be employed. If one is in any doubt as to the treatment of a patient of this sort, it probably would be well to get the advice of a colleague specializing in this type of work.

4. In dementia paralytica all patients should have a preliminary course of malarial therapy, from twelve to fifteen chills, following which the patients may be treated with alternating courses of arsenicals and bismuth compounds or, if examination of the eyegrounds has been made and the fields are found to be not contracted, it may be possible to use tryparsamide, weekly injections being given over a long period. The Cooperative Group advises as much as from thirty to forty injections, provided no eye symptoms intervene. Following this, alternating bismuth and arsenical injections may be used, and, of course, potassium iodide should be employed consistently.

5. One would hesitate to say that a man of 50 years is senile. Many individuals are in vigorous condition at this age, and it might well be that they could receive the same treatment as patients in group 1. If one is dealing with an actual senile case, for example a man of 65 with syphilis, naturally it will be impossible to cure the patient's syphilis, and such an individual should be treated symptomatically, probably with potassium iodide, injections of a bismuth compound or mercury rubs.

In treating paretic patients with a psychosis, malaria should be employed if the patient is in good enough physical condition. Even in an advanced form of the disease, patients sometimes respond in a remarkable manner.

Aqueous solutions of bismuth are of value in cases in which the injections can be given at least twice a week. The great difficulty is that the physician uses an aqueous solution in an injection once a week and feels that he has exhibited enough bismuth to take care of the patient's syphilis. With an aqueous preparation of bismuth it is not possible to raise the level of bismuth in the blood stream to a therapeutic level through a single weekly injection. They must be given twice or three times a week. On that account, in ambulatory patients the physician will usually find it preferable to employ one of the bismuth suspensions; for example, bismuth salicylate or potassium bismuth tartrate. For the student desirous of going further into this problem we would recommend that he consult "The Modern Treatment of Syphilis," by J. Earle Moore, Springfield, Ill., Charles C. Thomas, 1933; "Modern Clinical Syphilology," by John H. Stokes, second edition, Philadelphia, W. B. Saunders Company, 1934, or the publications of the Committee on Research in Syphilis, which have been appearing in the last few years in *Venereal Disease Information*, a publication of the United States Public Health Service.

HORMONE TREATMENT IN DELAYED GROWTH

To the Editor:—Is a roentgenogram of one hand and forearm sufficient evidence on which to base the statement that a boy, aged 11 years, has the bone development of a boy of 7 or 8 years? Also is the statement that unless the boy has biweekly injections of 2 cc. of antuitrin (Parke, Davis & Co.) the bones will not grow properly a tenable one? Granted that an 11 year old has the bone development of a boy of 7 or 8 years what, if any, treatment more than proper diet, vitamins, and so on, is indicated? In the case in question there is no clinical evidence of any faulty bone development except that on the roentgenogram. Please omit name.

M.D., New Hampshire.

ANSWER.—In the absence of clinical evidence of faulty bone development in the case in question, it is assumed that the 11 year old boy under discussion is of normal height and weight for his age. There is a lack of information as to clinical observations on mental, sexual and other physical attributes of development. If it is assumed that all other clinical evidence of growth and development in the boy is normal, a roentgenogram of one hand and forearm would not be sufficient evidence for the statement that there had been a retardation in bone development. It is true that roentgen examination is a valuable aid in the study of growth, and a delay in the appearance of centers of ossification may be an index of general retardation in development. The hand has been chosen as the most satisfactory and useful portion of the skeleton to study bone development. In general it may be said that the infant at 1 year of age will show ossification of two or three carpal bones and that all the carpal bones should show centers of ossification at 6 years of age. Thus one may roughly estimate the age of the infant or child by the number of carpal bones ossified and by the degree of ossification. From a roentgenogram of the hand and wrist of an infant or child, one may estimate the approximate age of the individual. However, there is a fairly wide variation within the normal, and if growth and development are otherwise normal, as has been assumed in this case, it is probable that the roentgenographic evidence could be considered within the lower limits of the normal range. In some conditions in which general growth and development are abnormal, a delay in ossification as shown by roentgenograms of the carpus will have diagnostic significance. Among such conditions may be enumerated congenital or acquired hypothyroidism, rickets and renal rickets, celiac disease, types of dwarfism such as the Lorrain type of infantilism, the ateliosis of Gifford, and the Paltauf type of dwarfism. Treatment in any given case will depend on the cause of the general retardation in development. In a case of delayed ossification due to avitaminosis, such as rickets, the treatment would consist in supplying vitamin D in adequate amounts. In the case of aspecific hormone deficiency, such as hypothyroidism, the administration of thyroid would be indicated.

OCCUPATIONAL HAZARDS OF CONCRETE INDUSTRY

To the Editor:—Will you please send me literature on the possible allergic manifestations from concrete and the ingredients of cement, as well as literature on occupational dermatoses that might arise from concrete making?

P. B. BRUMBY, M.D., Lexington, Miss.

ANSWER.—The raw materials of Portland cement vary slightly from plant to plant and from type to type. The basic material is limestone, to which may be added shale, clays, clinkers, silica sand, slag, hydrous aluminum silicate and gypsum. After the mixture has been calcined, the resulting compound is essentially a mixture of calcium silicates. The proportion of free alkali is low, being of the order of 0.2 per cent, but the calcium silicate itself may act as an alkaline irritant. On the addition of water, as in the making of the concrete mixture, the calcium silicates are modified so as to produce more free alkali as calcium hydroxide. It follows that concrete makers are handling a more hazardous material than is true for cement makers. In a cement plant employing about 743 persons, only thirty-seven cases of disabling skin disease of any character took place in a period of three years. Furunculosis was the principal skin disease observed (Thompson and others, "Health of Workers in a Portland Cement Plant," Pub. Health Bull. 176, 1928). A true allergic dermatitis following exposure to cement is open to question but has been described by Cohen and Ganot (*Bull. Soc. franç. de dermat. et syph.*, July 1931, p. 1135). Martial states that at least one third of workers handling lime and cement acquire "cementers' itch." Among cement makers a dermatitis has been found in finishers, packers and bag cleaners. Perspiration and other sources of wetness favor the occurrence of skin disorders. In some trades mechanical abrading has to be considered along with the chemical irritation. In addition to the acute dermatitis venenata, a variety of chronic manifestations are recognized, including deep fissures, nail splitting and friability, skin tautness, and ulcers invaded by fungi. The alkali content of cement and of concrete is uniformly accorded chief consideration as the cause of the skin involvement. Additional comment may be found in:

International Labor Office: Occupation and Health, Geneva, 1934.
Anstett, F.: Cementers' Itch, Bull. Acad. de méd., Oct. 20, 1925, p. 902.

MULTIPLE IMMUNIZATION

To the Editor:—In the Dec. 28, 1935, issue of THE JOURNAL a question is asked regarding the use of Sauer's whooping cough vaccine. The answer states that active immunizations against pertussis, scarlet fever, diphtheria and smallpox should be separated, each from the others, by intervals of several months in order to prevent one from "conflicting with the other." As each such immunization is specific in nature, I am wondering about the mechanism of such conflict. If these several immunizations were all performed at the same time, or close together, would the immunity subsequently developed against each infection be less as a result of this conflict than if more widely separated? If so, does this same consideration exist when simultaneously immunizing children or adults against smallpox, typhoid fever and cholera?

CARR E. BENTEL, M.D., Medical Corps, U. S. Navy.

ANSWER.—There is no definite proof that concurrent pertussis and diphtheria immunization is undesirable. With between 10 and 15 per cent failures with authorized commercial pertussis vaccine it seems advisable to give the pertussis vaccine a chance, without further complicating matters. When there become available reports of a higher percentage of protection with the commercial vaccine, it would be of interest to try a series of several hundred simultaneous immunizations to determine whether immunity is so influenced. In the present state of our knowledge and experience, it does not seem advisable now to undertake simultaneous injections. Since it is rarely if ever necessary to crowd the various immunization procedures, it seems prudent to allow a sufficient time interval after each to insure the highest degree of immunity response.

FOOD POISONING

To the Editor:—I have been treating a young married woman since July 1935 for a spastic colon. Although the condition was annoying, she was never in acute distress. About the latter part of December she ate a few slices of whole wheat bread and approximately four hours later was seized with violent, generalized abdominal pains accompanied by nausea, vomiting and later diarrhea. About twelve hours later she appeared to be in a stage of shock with its usual manifestations. It required about a week's care to restore her to her original condition. It was discovered on the same day on which she ate the bread that, although apparently fresh, it contained a greenish, white velvety fungous growth inside the bread measuring about 2 inches long and half an inch wide. There is no doubt that the bread consumed had contained this growth. Kindly give me information concerning this form of food poisoning and any references you may have available. Please do not publish my name.

M.D., Pennsylvania

ANSWER.—While within the range of possibility, it is not likely that this was an allergic manifestation. The description is characteristic of acute food poisoning such as has been described for certain strains of staphylococci, of which Jordan and Burrows (*Am. Jour. Hyg.* **20**:604 [Nov.] 1934) have recorded nine outbreaks; recently Dack, Bowman and Harger (THE JOURNAL, Nov. 16, 1935, p. 1598) described another. It is possible that the green mold was the cause, but unlikely, as other molds, including green ones, growing on bread have not been incriminated as food poisons although probably they are frequently eaten. One must remember, however, that mushrooms are distant cousins of such fungi. It would seem more likely that the food poisoning in this case was caused by some other organism and the most likely explanation, since the disability did not last longer than a week, is that one of the staphylococci was responsible.

BURNS AND DIABETES

To the Editor:—Can you give me any information or references to the literature with regard to burns as a cause of diabetes?

LEO F. SCHIFF, M.D., Plattsburg, N. Y.

ANSWER.—Notwithstanding a considerable study of so-called instances of trauma in relation to the onset of diabetes, no case of burns as a cause of the disease is recalled. It is true that one boy developed diabetes two weeks following a severe sunburn and a physician told the mother that the pancreas was injured by the burn!

Burns as an etiologic factor in diabetes would appear to be unexplainable.

However, a mild diabetes can be made extremely severe by burns. Thus a woman, aged 66, with diabetes of seven years' duration, both of whose legs had been amputated for gangrene, upset a kettle of boiling water over her body while sitting in her wheel chair. She was unable to extricate herself. The following day vomiting began and on the fourth day she entered the hospital in diabetic coma. Although she recovered from the coma, she succumbed to the trauma resulting from the burn and the coma twenty-one days later. Three months before the accident, although her heart was fibrillating during a stay in the hospital, she was sugar free with carbohydrate 145 Gm., protein 50 Gm. and fat 76 Gm., and the fasting blood sugar was 170 mg. per hundred cubic centimeters without insulin.

FACTORS AFFECTING VIABILITY OF SPERM

To the Editor:—In the paper on natural conception control by Dr. Latz in THE JOURNAL, Oct. 19, 1935, he discusses factors governing the periodicity in the fertility and sterility of women in part as follows (p. 1241): "1. The life of the sperm cell within the female genitalia is less than forty-eight hours. The most important factor influencing the length of the fertility of the spermatozoa in a harmful way is the body temperature within the vagina. The scrotum serves as a refrigerating apparatus for the testicles, keeping the spermatozoa at a temperature which is several degrees lower than that of the circulating blood." To one who is interested in the subject of fertility and sterility in animals, the question arises as to what effect, if any, the seminal vesicles may have in offsetting the so-called refrigerating action of the scrotum. So far as the lower animals are concerned, most of them have seminal vesicles which, it is understood, act as reservoirs for the collection of spermatozoa and spermatic fluid. From the location of the vesicles within the abdominal cavity, it would seem that the spermatozoa are there subjected to temperatures equal to those which would obtain in the vagina. If this is true and if the viability of the spermatozoa is affected adversely by such high temperatures, what may be said about the effect of the latter on the germ cells while they are in the seminal vesicles? Please omit name.

V.M.D., New Jersey.

ANSWER.—In answering the question as to the effect of the temperature in the vesicle or vagina on the spermatozoa it must be understood that, although a temperature a few degrees lower than the body may be necessary for spermatogenesis or the production of spermatozoa, the mature sperm cells can and do live at body temperatures that exist in the vagina or the vesicles. The longer life of spermatozoa in the vesicle as compared with their short life in the vagina is due to more than one factor; in the first place the vesicle produces a secretion that activates or feeds the spermatozoa (this secretion is naturally absent in the vagina) and, secondly, the high bacterial content and often the acid reaction of the vagina are adverse factors for the life of the sperm cells.

WASHING PERITONEAL CAVITY

To the Editor:—Bevan (*S. Clin. North America* **15**: 681 [June] 1935) advises in peritonitis the washing out of the general peritoneal cavity with physiologic solution of sodium chloride. Is there general agreement on the point that irrigation is advisable? I refer to the conception that irrigation removes plastic exudate and thus allows increased absorption of toxins by the peritoneum. Please discuss. M.D., Pennsylvania.

ANSWER.—There is no general agreement on the point that irrigation of the peritoneal cavity in general peritonitis is advisable. There does seem to be agreement that there is value in removing fluids from the abdomen within the six hours subsequent to perforation, penetration or rupture of a hollow abdominal viscus. This can best be done by means of a suction apparatus. There is no objection to washing out the general peritoneal cavity during an operative procedure in which local contamination has occurred.

DEODORIZED KEROSENE

To the Editor:—In THE JOURNAL, Nov. 2, 1935, p. 1455 in Queries and Minor Notes, deodorized kerosene was suggested in the treatment of scalp conditions. I have inquired at several places but no one seems to know where I can buy deodorized kerosene. I would appreciate it greatly if you could tell me where such a product is sold. Please omit name.

M.D., Massachusetts.

ANSWER.—The Welty Company, 337 Sigel Street, Chicago, markets deodorized kerosene. It has only a slight kerosene odor and is said to be much less inflammable than ordinary kerosene. Besides its skin stimulating qualities it is a cleansing agent, dissolving greases, waxes and resins. It also is a solvent of camphor, iodine, menthol, thymol and other substances.

PAINFUL TONGUE

To the Editor:—A white woman, aged 68, has been complaining of a painful tongue for the past year. The majority of her foods seem peppery. The pain is intense, although there are occasional periods of remission. The surface of the tongue is smooth and red. There are no visible ulcerations. Her blood pressure is 240 systolic, 120 diastolic; red blood cells 2,750,000; hemoglobin 65 (Sahli); smear is normal; the urine shows albumin +++, with hyaline and granular casts. I have been treating her for the hypertension and anemia. Kindly advise as to treatment for sore tongue. Please omit name.

M.D., New York.

ANSWER.—A smooth, painful, red tongue in an elderly female associated with a hyperchromic anemia and a 1.5 color index is frequently seen in pernicious anemia.

Complete and careful blood studies should be performed. In addition, blood chemistry studies including nonprotein nitrogen, sugar, creatinine and serum proteins should be done. If the proteins are low, adequate intake should be provided. In addition, liver, either orally or parenterally, may be given. Diluted hydrochloric acid after meals may also be of value.

ANTIEMETIC COMBINATION

To the Editor:—Zahorsky in his "Synopsis of Pediatrics" speaks at length of the use of milk of magnesia and a minute amount of phenol as an antiemetic. Could you kindly advise the exact amount of each substance? Please omit name.

M.D., Illinois.

ANSWER.—The addition of as small a quantity as 0.05 Gm. of phenol to a teaspoonful or tablespoonful dose of magnesia magma would constitute a suitable antiemetic combination.

DOSAGE OF CHLORAL IN ECLAMPSIA

To the Editor:—In the 1935 supplement of volume XVIII of Sajous' Cyclopedia of Medicine, page 570, appears the following about eclampsia: "Patients who are very restless should be given chloral hydrate 20 Gm. (5 drachms) and sodium bromide 60 Gm. (2 ounces) by rectum." I never thought it was possible to give such a heavy dose of chloral and bromide. In my other medical books the largest dose prescribed in such cases is: chloral hydrate 4 Gm. (1 drachm) and sodium or potassium bromide 8 Gm., or 2 drachms. OVILA BIRS, M.D., Coaticook, Que.

ANSWER.—There is an obvious error in this statement, as from 6 to 12 Gm. of chloral hydrate has produced death. The doses quoted as "largest doses" should be accepted as such.

Medical Examinations and Licensure

COMING EXAMINATIONS

STATE AND TERRITORIAL BOARDS

ALASKA: Juneau, Sept. 1. Sec., Dr. W. W. Council, Juneau.

ARIZONA: Phoenix, July 7-8. Sec., Dr. J. H. Patterson, 826 Security Bldg., Phoenix.

ARKANSAS: *Basic Science.* Little Rock, Nov. 2. Sec., Mr. Louis E. Gebauer, 701 Main St., Little Rock. *Medical (Regular).* Little Rock, Nov. 10. Sec., Dr. A. S. Buchanan, Prescott. *Medical (Eclectic).* Little Rock, Nov. 10. Sec., Dr. Clarence H. Young, 207½ Main St., Little Rock.

CALIFORNIA: San Francisco, July 6-9, and Los Angeles, July 20-23. Sec., Dr. Charles B. Pinkham, 420 State Office Bldg., Sacramento.

COLORADO, Denver, July 7. Sec., Dr. Harvey W. Snyder, 422 State Office Bldg., Denver.

CONNECTICUT: *Medical (Regular).* Hartford, July 14-15. *Endorsement.* Hartford, July 28. Sec., Dr. Thomas P. Murdock, 147 W. Main St., Meriden. *Medical (Homeopathic).* Derby, July 14. Sec., Dr. Joseph H. Evans, 1488 Chapel St., New Haven.

DELAWARE: Dover, July 14-16. Sec., Medical Council of Delaware, Dr. Joseph S. McDaniel, Dover.

DISTRICT OF COLUMBIA: Washington, July 13-14. Sec., Commission on Licensure, Dr. George C. Ruhland, 203 District Bldg., Washington.

HAWAII: Honolulu, July 13-16. Sec., Dr. James A. Morgan, 48 Alexander Young Bldg., Honolulu.

IDAHO: Boise, Oct. 6. Commissioner of Law Enforcement, Hon. Emmitt Pfost, 205 State House, Boise.

IOWA: *Basic Science.* Des Moines, July 14. Sec., Prof. Edward A. Benbrook, Iowa State College, Ames.

MAINE: Augusta, July 7-8. Sec., Board of Registration of Medicine, Dr. Adam P. Leighton, 192 State St., Portland.

MASSACHUSETTS: Boston, July 14-16. Sec., Board of Registration in Medicine, Dr. Stephen Rushmore, 413-F State House, Boston.

MONTANA: Helena, Oct. 6. Sec., Dr. S. A. Cooney, 7 W. 6th Ave., Helena.

NEW HAMPSHIRE: Concord, Sept. 10-11. Sec., Board of Registration in Medicine, Dr. Charles Duncan, State House, Concord.

NEW MEXICO: Santa Fe, Oct. 12-13. Sec., Dr. Le Grand Ward, Santa Fe.

NORTH DAKOTA: Grand Forks, July 7-10. Sec., Dr. G. M. Williamson, 4½ S. 3d St., Grand Forks.

OREGON: *Basic Science.* Corvallis, July 18. Sec., Mr. Charles D. Byrne, University of Oregon, Eugene.

PENNSYLVANIA: Philadelphia and Pittsburgh, July 7-11. Sec., Board of Medical Education and Licensure, Mr. Clarence E. Ackley, 400 Education Bldg., Harrisburg.

PUERTO RICO: San Juan, Sept. 1. Sec., Dr. O. Costa Mandry, Box 536, San Juan.

RHODE ISLAND: Providence, July 2-3. Chief, Division of Examiners, Mr. Robert D. Wholey, 366 State Office Bldg., Providence.

SOUTH DAKOTA: Rapid City, July 21-22. Dir., Division of Medical Licensure, Dr. Park B. Jenkins, Pierre.

UTAH: Salt Lake City, July 10. Dir., Department of Registration, Mr. S. W. Golding, 326 State Capitol Bldg., Salt Lake City.

WASHINGTON: *Basic Science.* Seattle, July 9-10. *Medical.* Seattle, July 13-15. Dir., Department of Licenses, Mr. Harry C. Huse, Olympia.

WEST VIRGINIA: Bluefield, July 13. State Health Commissioner, Dr. Arthur E. McClue, Charleston.

WISCONSIN: Milwaukee, June 30-July 3. Sec., Dr. Robert E. Flynn, 401 Main St., La Crosse.

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS. *Parts I and II.* Sept. 14-16. Ex. Sec., Mr. Everett S. Elwood, 225 S. 15th St., Philadelphia.

SPECIAL BOARDS

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY: Written examination and review of case histories of Group B candidates will be held in various cities in the United States and Canada, Nov. 7. *Applications must be filed at least sixty days prior to the examination.* Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh (6).

AMERICAN BOARD OF OPHTHALMOLOGY: New York, Sept. 26. *All applications and case reports must be filed sixty days before date of examination.* Address, 122 So. Michigan Ave., Chicago.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY: Cleveland, Jan. 9. Sec., Dr. Fremont A. Chandler, 180 N. Michigan Ave., Chicago.

AMERICAN BOARD OF OTOLARYNGOLOGY: New York, Sept. 25-26. Sec., Dr. W. P. Wherry, 1500 Medical Arts Bldg., Omaha.

AMERICAN BOARD OF PEDIATRICS: Baltimore and Cincinnati in November. Sec., Dr. C. A. Aldrich, 723 Elm St., Winnetka, Ill.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: New York, Dec. 29-30. Sec., Dr. Walter Freeman, 1028 Connecticut Ave., Washington, D. C.

AMERICAN BOARD OF RADIOLOGY: Cleveland, Sept. 25-27. Sec., Dr. Byrl R. Kirklin, Mayo Clinic, Rochester, Minn.

California Reciprocity and Endorsement Report

Dr. Charles B. Pinkham, secretary, California State Board of Medical Examiners, reports 30 physicians licensed by reciprocity and 3 physicians licensed by endorsement from Feb. 6 through April 2, 1936. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
University of California Medical School		(1934)	Washington
University of Colorado School of Medicine		(1934)	Colorado
American Medical Missionary College, Chicago		(1900)	Mass.
Loyola University School of Medicine		(1933)	Illinois
Northwestern University Medical School		(1929)	Ohio
University of Illinois College of Medicine		(1918), (1920)	Illinois
State University of Iowa College of Medicine		(1933)	Iowa
Tulane University of Louisiana School of Medicine		(1934)	Louisiana
Baltimore Medical College		(1909)	New York
Johns Hopkins University School of Medicine.		(1906), (1933), (1926)	Maryland, Minnesota
Harvard University Medical School		(1928)	Wisconsin
Detroit College of Medicine		(1907)	Michigan
University of Minnesota Medical School		(1929), (1932)	Minnesota
St. Louis University School of Medicine		(1932)	Missouri
Creighton University School of Medicine		(1933)	Utah
University of Nebraska College of Medicine		(1919), (1925)	Nebraska, Illinois
Columbia Univ. College of Physicians and Surgeons		(1930)	New York
Long Island College Hospital		(1929)	New York
Long Island College of Medicine		(1931)	New York
New York University, University and Bellevue Hospital Medical College		(1931)	New York
University of Cincinnati College of Medicine		(1927)	Ohio
University of Pittsburgh School of Medicine		(1930)	Penna.
University of Wisconsin Medical School		(1929)	Oklahoma
Western University Faculty of Medicine, Ontario		(1902)	New York
Regia Università di Napoli Facoltà di Medicina e Chirurgia		(1922)	Penna.

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
Rush Medical College		(1932)	U. S. Navy
Medico-Chirurgical College of Philadelphia		(1916)	U. S. Army
Woman's Medical College of Pennsylvania		(1921)	N. B. M. Ex.

Alabama Reciprocity and Endorsement Report

Dr. J. N. Baker, secretary, Alabama State Board of Medical Examiners, reports 15 physicians licensed by reciprocity and 1 physician licensed by endorsement from Jan. 13 through April 20, 1936. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Howard University College of Medicine		(1932)	Georgia
Emory University School of Medicine		(1933), (1934)	Georgia
Tulane Univ. of Louisiana School of Med.		(1931), (1934)	Louisiana
University of Michigan Medical School		(1931)	Michigan
Washington University School of Medicine		(1930)	Missouri
Temple University School of Medicine		(1932)	S. Carolina
Memphis Hospital Medical College		(1904)	Tennessee
Univ. of Tennessee College of Medicine		(1933, 2), (1934, 2)	Tennessee
Vanderbilt University School of Medicine		(1928), (1934)	Tennessee

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
Columbia Univ. College of Physicians and Surgeons		(1933)	N. B. M. Ex.

South Dakota January Report

Dr. Park B. Jenkins, director, Division of Medical Licensure, reports the written and practical examination held in Pierre, Jan. 21-22, 1936. The examination covered 14 subjects and included 105 questions. An average of 75 per cent was required to pass. Three candidates were examined, all of whom passed. Three physicians were licensed by reciprocity. The following schools were represented:

School	PASSED	Year Grad.	Per Cent
Boston University School of Medicine		(1934)	87
University of Minnesota Medical School		(1935)	84
St. Louis University School of Medicine		(1927)	85

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Georgetown University School of Medicine		(1924)	Ohio
Northwestern University Medical School		(1924)	Michigan
University of Tennessee College of Medicine		(1934)	Tennessee

Rhode Island January Examination

Mr. Robert D. Wholey, chief, Division of Examiners, reports the oral, written and practical examination held at Providence, Jan. 2-3, 1936. The examination covered 20 subjects and included 50 questions. An average of 80 per cent was required to pass. Four candidates were examined, 3 of whom passed and 1 failed. Two physicians were licensed by endorsement. The following schools were represented:

School	PASSED	Year Grad.	Per Cent
Harvard University Medical School		(1932)	88.9
Tufts College Medical School		(1934)	80
Hahnemann Med. College and Hospital of Philadelphia		(1935)	85.4

School	FAILED	Year Grad.	Per Cent
Laval University Faculty of Medicine		(1934)	40

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
Harvard University Medical School		(1932, 2)	N. B. M. Ex.

Book Notices

Lobar Pneumonia and Serum Therapy, with Special Reference to the Massachusetts Pneumonia Study. By Frederick T. Lord, M.D., Member of the Board of Consultation, Massachusetts General Hospital, and Roderick Heffron, M.D., Field Director, Pneumonia Study and Service, Massachusetts Department of Public Health. Cloth. Price, $1. Pp. 91, with 11 illustrations. New York: Commonwealth Fund; London: Oxford University Press, 1936.

The authors of this manual have placed physicians and students in their debt by a succinct presentation of the elements of serum therapy for lobar pneumonia due to pneumococcus types I and II. They provide evidence of the success of serum therapy based on a study of more than 900 patients who were treated by 400 physicians. They are correct in stating that specific treatment in the hands of general practitioners presents a community problem because of the need for prompt typing and the provision of serum for those unable to afford it. The chapters cover the application of specific therapy to lobar pneumonia, etiology, factors influencing recovery, clinical diagnosis and selection of cases, the recognition of the pneumococcus type, antipneumococcus serum, administration of serum and dosage, serum reactions and their treatment, and the results of serum treatment. The procedures recommended are sound. The importance of studying cultures of the heart's blood or the brain of sputum-injected mice is not mentioned, though in some instances they are the first source of knowledge of the type. No method of gaging the adequacy of the dose of serum before clinical improvement or when invasion by an additional organism has occurred is described, though two are available: the presence of agglutinins in the patient's blood and the Francis test or the skin reaction to the specific carbohydrate. There are, as there must be in a subject that is developing, many points in which more experience will bring modification of opinion and practice. Warming serum above hand temperature may be a source of difficulty and should not be recommended.

Lésions du pancréas et troubles fonctionnels pancréatiques: Diagnostic en clinique par l'épreuve à la sécrétine purifiée. Par Marc Bolgert. Préface du Professeur G. Roussy. Paper. Price, 45 francs. Pp. 225, with 22 illustrations. Paris: Masson & Cie, 1935.

In this monograph Bolgert, working in the clinic of Professor Chiray and in the laboratory of Professor Roussy, reports the effect produced on the secretion of the pancreatic juice by the intravenous injection of purified secretin. After bile samples A, B and C have been secured according to the recognized Meltzer-Lyon technic, secretin is given. Trypsin and lipase are then determined in the clear secretion of the pancreatic juice. Eighty cases of various types of pancreatic disease were studied by this method and the results are presented. There are excellent illustrations of disease of the pancreas found in association with the cases under investigation. Thus, figure 15 is an illustration of a pancreas filled with calcified granules and in this case the volume of the juice after the secretin injection as well as the lipase and trypsin were reduced. A discussion of similar cases in the literature is included. In Bolgert's patient the fasting blood sugar was normal but subsequently advanced to a mild diabetic level. Following the injection of secretin the pancreatic response is immediate or occurs after a few minutes' delay. Fluid is collected from the duodenal tube every five or ten minutes and the volume noted. Its content in lipase and trypsin is determined. The secretion lasts for about twenty-five minutes but can be prolonged. It is then often mixed with gastric juice. Methods of the determination of lipase and trypsin are recorded. In normal cases the pancreatic response is immediate, and the volume of the juice excreted is much increased, reaching from 100 to 150 cc. in fifteen or twenty minutes and the lipase and trypsin are more than doubled after the injection. In abnormal cases the pancreatic response is delayed and there is a diminution of the quantity of the enzymes. Generally if there is a change in one ferment the other follows suit. In part I the book presents a comprehensive study of pancreatic symptomatology based on clinical, x-ray and pathologic methods. In part II the action of secretin, the technic of administration, the results of the test and its interpretation are described, and in part III functional pancreatic disturbances as found in the course of various diseases of the pancreas, liver and gallbladder, and other states are touched on. It would appear that this monograph advances definitely the opportunity for learning the functional changes that are taking place in the pancreas and opens up methods that can be tried generally in the clinic to solve the diagnosis of conditions of a gland hitherto always difficult to investigate.

A Guide to Psychiatric Nursing. By F. A. Carmichael, M.D., Superintendent, Osawatomie State Hospital, Osawatomie, Kansas, and John Chapman, M.A. Second edition. Cloth. Price, $2.25. Pp. 175, with 31 illustrations. Philadelphia: Lea & Febiger, 1936.

It is at once apparent that this book is the result of mature judgment. It had its inception in a course of lectures for the nurses in the Osawatomie State Hospital. The present edition is well written and the illustrations are excellent. It is intended especially for training the psychiatric nurse, which purpose it should serve with credit. The book is well arranged. The introductory chapter is on the history of psychiatry and it takes the student in an orderly manner through the various developmental stages of mental history. The chapter on definitions of mental disease is rather short and might better have been incorporated in one of the following chapters. The classification of mental diseases employed by the authors is one modified from that of Henderson and Gillespie. There is a short but excellent chapter on psychopathology which, however, may be a little difficult for the average student nurse to comprehend. The same may be said of the chapter on the etiology of mental disease. Chapter 10, which is given over to the symptomatology of mental disease, contains many practical bits of information for the nurse and, as the authors suggest, what they wish "to impress on nurses is the value of accurate and detailed observation." It is rather surprising that no more space is given to the discussion of encephalitis, mental deficiency, and some of the psychoneuroses, especially neurasthenia. The sane handling of patients is emphasized. As is stated in the preface, "above all, we stress the point that these unfortunates who have been committed to our care are human, neither wild beasts in some instances nor beasts of burden in others." Appendix A, which deals with hereditary factors in mental defects and disease, while appropriate, might just as well have been included in the chapter on etiology of mental diseases. Appendix B, which deals with a proposed modification of the present classification of mental diseases, seems a little profound for the average student nurse but might be referred to in the chapter on the classification of mental diseases. The book represents a new and refreshing method of presentation of its material. It contains many good references for collateral reading and, all in all, should be of considerable help in the teaching of psychiatry to nurses.

Geopsyche: Die Menschenseele unterm Einfluss von Wetter und Klima, Boden und Landschaft. Von Dr. Dr. Willy Hellpach, Professor an der Universität Heidelberg. Fourth edition of "Geopsychische Erscheinungen." Cloth. Price, 9.50 marks. Pp. 317. Leipzig: Wilhelm Engelmann, 1935.

The fact that Hellpach's book "Geopsyche" (the 1923 edition was published under the title of Geopsychische Erscheinungen) has reached a fourth edition must indicate a growing continental interest in the study of man as a creature of his environment; an interest in the patient as diseased because of maladjustment to the world about him. But Hellpach is not an environmentalist in the sense of the psychologist. For him, environment is the universe—more particularly the "airs, waters, places" on which Hippocrates built his structure. In the English speaking countries this point of view is still medically remote, though in the collateral sciences, in general biology, in zoology, in botany, a broader concept is forging ahead, if Livingston's evaluation is correct. This edition has been almost entirely rewritten and the material has been carefully selected, condensed and amplified. As it now stands it presents an excellent review of the interrelation of the environment and the psychic phenomena. Fundamentally Hellpach's interests relate to the effects of climate, in contradistinction to the immediate meteorological effects that are experienced as weather change, though even here the treatment is adequate. Diurnal rhythm, seasonal rhythm, the rhythm of the lunar cycle are all discussed, as are the effects of local geographic and geological differences. A whole section is devoted to the psychic effects of the landscape

on the individual and on the racial group. The psychologist and the psychiatrist interested in the wider aspect of his subject is presumably familiar with the previous editions; for the younger German reading members of these groups the new edition should prove interesting as well as useful.

The Art of Ministering to the Sick. By Richard C. Cabot, M.D., and Russell L. Dicks, B.D. Cloth. Price, $3. Pp. 384. New York: Macmillan Company, 1936.

Dr. Richard Cabot has been for many years a leading clinician and teacher of scientific medicine. He has also been an eloquent exponent of the social side of medicine and the human side of illness. His books on Physical Diagnosis and Facts on the Heart have companion volumes in What Men Live By and Social Service and the Art of Healing. In this work he has as co-author a minister of the gospel. The theme that is developed is that in time of painful or incapacitating illness, even when the patient is knowingly rapidly approaching death, there is something more to be done than to try to work a cure or alleviate physical suffering. Encouragement and psychic therapy are helpful but may not go far enough. Religion has a place. Its comfort may be brought not only to the orthodox believer but to the backslider, the doubter, the agnostic or the frank disbeliever. This religion need not be, nor should it be, narrowly sectarian. Rightly handled it is helpful in restoring mental poise and happiness; it may have a wholesome effect on the physical ailment. This is the belief of the authors based on a rich experience, of which they give illustrative examples. Those who are interested in these features of medical practice —and all should be—will find here much food for thought and many helpful suggestions. The authors ask for specific criticisim of certain views that they hold—some tentatively, perhaps. In a brief book notice it is hardly in place to express opinions, much less to advance arguments pro or con. The authors will no doubt welcome such criticism as helpful. It is to be hoped that many readers will offer this frankly asked for comment.

Alimentación y dietética. Por el Dr. Mario Schteingart, docente libre de patología médica de la Facultad de medicina de Buenos Aires. Paper. Pp. 583, with one illustration. Buenos Aires: Aniceto Lopez, 1935.

This appears to be a useful textbook on dietetics, containing as it does a good deal of information not only as to the more technical aspects of dietetics but also as to the more practical ones. The first chapters are on calorimetry, basal metabolism and the constitution and caloric values of the several foods. Then there are chapters on the feeding of children, pregnant women and the aged. Three chapters are devoted to a discussion of the problems of feeding as they apply particularly to Argentina. In the final third of the book the author gives practical details of the dietetic treatment of the several diseases in which dieting is most effective. In the last two chapters Schteingart gives some advice about the preparation of foods for the sick, together with a number of recipes. The book can be recommended to physicians who read Spanish.

La litiasis reno-ureteral bilateral. (Estudio clínico e indicaciones en su tratamiento). Por el Dr. Pedro Cifuentes, cirujano-urólogo y decano-jefe del Hospital de la Beneficencia General. Paper. Pp. 83, with illustrations. Madrid: Grafica Universal, 1935.

Dr. Cifuentes has studied ninety-seven cases of reno-ureteral lithiasis in which operation was performed. The cases are carefully charted according to history, treatment and results. Some excellent plates are included as well as a fairly comprehensive bibliography. It is stated that the average incidence of bilateral renal lithiasis is 21 per cent, which seems to be an average figure, judging from the divergence of reports that may be found in the literature. When speaking of bilateral lithiasis, the author differentiates between medical and surgical bilateral lithiasis. The problem of medical bilateral lithiasis seems to have been discussed in other papers and is not treated in this work. His concept of bilateral lithiasis includes (1) renal lithiasis with surgical indications on both sides, (2) surgical stones on one side and stones with medical indications in the other, and (3) surgical lithiasis in one side with medical or surgical lithiasis ultimately appearing in the other kidney. The frequent association of bilateral lithiasis with urinary infection is noted, and this is considered one of the etiologic factors, as well as the influence of diathesis, alkalis, nutrition and osteomalacia. Emphasis is placed on the importance of complete roentgen examination, including pyelograms and retrograde, intravenous and pneumoradiography before the operation is undertaken. The author recommends that the kidney with the best function be operated on first, thereby minimizing shock and restoring as much function as possible before the kidney with more serious involvement is treated. The cases have been carefully worked out and the author has presented his material convincingly.

How the President, Thomas Jefferson, and Doctor Benjamin Waterhouse Established Vaccination as a Public Health Procedure. By Robert H. Halsey, M.D. Presented Before the Section of Historical and Cultural Medicine, New York Academy of Medicine, March 14, 1934. History of Medicine Series, No. 5, Issued under the Auspices of the Library of the New York Academy of Medicine. Paper. Price, $1. Pp. 58, with 3 illustrations. New York: The Author, 1936.

Historians in the field of medicine know that Dr. Benjamin Waterhouse was probably chiefly concerned with the introduction of smallpox vaccination into the United States. Few, however, have stopped to realize how significant was his experiment or the extent to which it concerned the nation as a whole. Dr. Robert Halsey has collected from many sources the details of this incident and he presents the story with numerous quotations of letters and papers, which give a good understanding of the situation. Few people realize the extent to which Thomas Jefferson was interested in these experiments and how significant was his influence in aiding the introduction of vaccination into this country. Without his help many years might have elapsed before it was recognized as an established public health measure.

An Epitome of the Laboratory Diagnosis and Treatment of Tropical Diseases. By Horace M. Shelley, F.R.F.P.S., M.R.C.S., L.R.C.P., Government Pathologist, Nyasaland, East Africa. Cloth. Price, 2s. 6d. Pp. 81. London: John Bale, Sons & Danielsson, Ltd., 1936.

This small pocket manual is too elementary and incomplete to assist the experienced physician in actual practice, and too indefinite and brief to assist the inexperienced physician. It omits much recent work in the field of its title; e. g., in the insufficient and poorly balanced discussion of the treatment of amebiasis, malaria, roundworms and sprue. The illustrations are of doubtful value as diagnostic aids. Dangers of drug toxicity are not evaluated; e. g., in the recommendation of emetine dosage and of acetarsone (stovarsol). The two short paragraphs on heat stroke are completely archaic. Careless and vague statements are found, as on page 22, where in the treatment of blackwater fever it is urged that the patient "be kept absolutely quiet in bed in a dorsal decubitus," . . . and "he should therefore perform his excretory functions in the prone position." Enough has been noted to show that the booklet is not satisfactory for the purpose designed in the title.

Diet Manual of University Hospital, University of Michigan. Prepared by the Department of Dietetics, University Hospital. Second edition. Cloth. Price, $1. Pp. 85. Ann Arbor: George Wahr, 1935.

The material in this manual is approved by the Department of Medicine, Surgery and Pediatrics of the University of Michigan Hospital. It lists the routine diets, special modifications such as diabetic, ketogenic, low and high calory diets, modifications of fibers, allergic diets, test meals and the special procedures used in pediatrics. The book is small, compact and useful.

Endocrine Tumours, and Other Essays. By Frederick Parkes Weber, M.A., M.D., F.R.C.P., Senior Physician to the German Hospital, London. Cloth. Price, 7s. 6d. Pp. 207. London: H. K. Lewis & Co., Ltd., 1936.

Any one interested in endocrine tumors should not be misled by the title, for a discussion of this subject occupies but thirty pages in the book and contains nothing new or worth while. A good idea of the character of the rest of the book may be gained from the subjects of a few of the essays: "change of air in young adult life and early middle age," "billiousness and bilious attacks, especially those induced in some persons by sea air," "regarding the 'stuff' of which dreams are made—the psychophysiologic basis of dreams." The author's style makes the book almost unreadable, there being but few pages that do not contain many parenthetical remarks. The essays are of no general interest. This book should have been distributed privately to the author's sympathetic friends.

Those Were Good Days! By Carl Ludwig Schleich. Translated by Bernard Miall. Cloth. Price, $3.50. Pp. 280, with 9 illustrations. New York: W. W. Norton & Company, 1936.

Dr. Schleich is known primarily for his contribution to local anesthesia. More than 365,000 copies of his autobiography have been sold in the German edition. He writes with a fine sense of humor, and his story is especially interesting because it is a record of the days when German medical science meant much to all the world. It was a time without the sadness, the agitation of the revolution characteristic of German medicine today. In all those who loved the old Germany this book will evoke a sad nostalgia. Especially interesting are the pages devoted to the work of Paul Ehrlich as Schleich saw him.

Pathologie digestive. Par P. Harvier, professeur à la Faculté de médecine de Paris. Collection des initiations médicales, publiée sous la direction du Dr A. Sézary. Paper. Price, 22 francs. Pp. 162, with 16 illustrations. Paris: Masson & Cie, 1935.

This is a primer for the student of gastro-enterology. The author discusses the subject in four chapters including motor, secretory and sensory disturbances and methods of examination. Emphasis is laid on the fact that all digestive disturbances are interrelated, and the divisions made are schematic for purposes of study. The more common disturbances are briefly but clearly treated, and illustrations are used to emphasize the more important diseases. The more complicated diseases are discussed briefly. The volume is easily read and should be of decided benefit to the young student.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Workmen's Compensation Acts: Silicosis Not an Occupational Disease.—The workman, Pero, was employed as an attendant on a rock-crushing machine. During the course of his employment, he contracted silicosis and was awarded compensation for several months. About three years later, claiming that he was suffering from permanent partial or total disability, he instituted proceedings for further compensation and the district court entered judgment in his favor. The state treasurer, representing the state compensation fund, appealed to the Supreme Court of Wyoming.

The Wyoming workmen's compensation act provides, in part:

> The words "injury and personal injury" shall not include injury caused by the wilful act of a third person directed against an employee for reasons personal to such employee, or because of his employment; nor a disease, except, as it shall directly result from an injury incurred in the employment.

It was contended that the workman was suffering from an occupational disease and that such a disease is not compensable under the Wyoming act. But, said the court, the workman in this case was not suffering from an occupational disease, as defined in *Victory Sparkler & Specialty Company* v. *Francks*, 147 Md. 368, 128 A. 635:

> An occupation or industry disease is one which arises from causes incident to the profession or labor of the party's occupation or calling. It has its origin in the inherent nature or mode of work of the profession or industry, and it is the usual result or concomitant. If, therefore, a disease is not a customary or natural result of the profession or industry, per se, but is the consequence of some extrinsic condition or independent agency, the disease or injury cannot be imputed to the occupation or industry, and is in no accurate sense an occupation or industry disease.

In the present case, continued the Supreme Court, neither the workman nor his employer regarded the inhalation of the rock dust emanating from the crusher as dangerous. No precautions were taken to protect the workman against such an injury as occurred. No one suggested to him the need for any protection. It was by chance that he was stationed for his work in such a position that the prevailing air currents during the period of his employment blew the dust clouds constantly on him. The exact date could be determined when he began to spit up blood as a consequence of the continued inhalation and cutting of sharp rock particles in his lungs. The time when the true character of his injury was discernible was equally determinable. There was, the court said, not a scintilla of evidence indicating that the injury suffered by the workman was the customary and natural result of the work in which he was engaged, nor was there any evidence that it was the usual result to be expected in working as he did during the period he was employed. There was no proof that any other workman, working under like conditions, ever suffered as did Pero. The record in the case, the court said, would not support a holding that the injury in question was an occupational disease. Whether the abnormal condition produced in the workman's lungs in consequence of the inhalation of the particles of rock dust is regarded as a disease or as a mechanical hurt, growing progressively worse, on account of the sharp particles retained in the lungs, it "directly" resulted, the court concluded, "from an injury incurred in the employment."

The award of compensation was therefore affirmed.—*In re Pero: Pero v. Collier-Latimer, Inc. (Wyo.), 52 P. (2d) 690.*

Optometry Practice Acts: Sufficiency of Notice of Revocation Proceedings.—The West Virginia optometry practice act authorizes the board of optometry to revoke the license of a licentiate for "advertising, practicing, or attempting to practice under a name other than one's own." It further provides that in revocation proceedings "a statement of the charges against the holder thereof and a notice of the time and place of hearing shall be served upon such person." The board instituted revocation proceedings against Eddy and served a notice on him, containing the following:

> You are hereby notified that the charges against you are that you are operating in violation of law; that you are operating through the Kay Jewelry, a corporation; that you have received from and are receiving from the Kay Jewelry a salary, purporting said salary to be a percentage of the payments made by certain customers whose names will be furnished to you upon request.

On receipt of this notice, Eddy instituted original proceedings in the Supreme Court of Appeals of West Virginia to restrain the board from proceeding further against him, contending that the notice served on him failed either to charge the violation of any law of the state or to set out any of the statutory grounds for which a license may be revoked.

The Supreme Court of Appeals was of the opinion, however, that the notice was sufficient fairly to inform Eddy of the nature of the misconduct for which it was proposed to revoke his license. He was advised by the notice that he was "operating in violation of law," and the particulars wherein he had violated the law were set out. The notice, in the opinion of the court, indicated on its face that the board accused Eddy of doing one of the acts which the optometry practice act made a cause for revocation; namely, "advertising, practicing, or attempting to practice under a name other than one's own." Furthermore, said the court, the legislature may constitutionally confer authority on the board of optometry to suspend or revoke a license.

The Supreme Court of Appeals accordingly denied Eddy the relief he sought.—*Eddy v. West Virginia Board of Optometry (W. Va.), 182 S. E. 870.*

Society Proceedings

COMING MEETINGS

American Physiotherapy Association, Los Angeles, June 28-July 2. Miss Jefferson I. Brown, Tichenor Hospital School, Long Beach, Calif., Secretary.

Montana, Medical Association of, Billings, July 8-9. Dr. E. G. Balsam, 208½ North Broadway, Billings, Secretary.

National Medical Association, Philadelphia, Aug. 16-22. Dr. W. Harry Barnes, 1315 North 15th St., Philadelphia, Acting Secretary.

Pacific Northwest Medical Association, Portland, Ore., July 8-11. Dr. C. W. Countryman, 407 Riverside Avenue, Spokane, Wash., Executive Secretary.

Wyoming State Medical Society, Cody, Aug. 24-25. Dr. Earl Whedon, 50 North Main Street, Sheridan, Secretary.

Current Medical Literature

AMERICAN

The Association library lends periodicals to Fellows of the Association and to individual subscribers to THE JOURNAL in continental United States and Canada for a period of three days. Periodicals are available from 1926 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 12 cents if two periodicals are requested). Periodicals published by the American Medical Association are not available for lending but may be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

Alabama Medical Association Journal, Montgomery

5: 337-372 (April) 1936

Oxygen Therapy in General Practice. M. E. Smith, America.—p. 337.
Some Moot Questions in Obstetrics. H. P. Hewitt, Chattanooga, Tenn. —p. 340.
*Treatment of Secondary Muscular Disturbances with Aminoacetic Acid: Preliminary Report. S. R. Terhune and A. H. Green, Birmingham. —p. 343.
Pain and Its Relief. O. R. Grimes, Gadsden.—p. 346.
Alabama's Eighty-Nine Years of Medical Organization: Brief History of the Association. D. L. Cannon, Montgomery.—p. 348.
Eye Diseases of Interest to the General Practitioner. D. Burkhead, Opelika.—p. 356.

Treatment of Muscular Disturbances with Aminoacetic Acid.—Terhune and Green became interested in muscular disturbances secondary to primary disease conditions because so many patients were referred for orthopedic consultation. Up to the present time they have used aminoacetic acid in five such cases, which are reported. The patients' chief complaints were chronic fatigue and easy fatigability. Aminoacetic acid was given in doses of from 30 to 45 Gm. a day. There was great improvement in each patient. The conclusions are that: 1. Aminoacetic acid is most likely of value in cases of primary muscle disturbances. 2. There may exist a syndrome of secondary muscular disturbances in disorders with different clinical aspects. 3. Secondary disturbances in muscle metabolism are ameliorated by the administration of aminoacetic acid. 4. The influence of aminoacetic acid therapy is probably solely confined to muscle metabolism.

American Journal of Diseases of Children, Chicago

51: 765-1006 (April) 1936

*Blood Picture After Splenectomy in Children, with Especial Reference to Platelets. Martha Wollstein and Katherine V. Kreidel, New York. —p. 765.
Values for Red Blood Cells of Average Infants and Children. E. R. Mugrage and Marjory I. Andresen, Denver.—p. 775.
*Rapid Typing of Pneumococci by Neufeld Reaction Directly from Laryngeal Swabs from Infants and Children. Julia Vinograd, Rosa Lee Nemir and W. H. Park, New York.—p. 792.
Metabolism of Adolescent Girls: I. Basal Metabolism and Energy Exchange. C. C. Wang, Mildred Kaucher and Mary Wing, Cincinnati.—p. 801.
Infantile Tetany: Metabolic Study. J. B. Pincus and I. F. Gittleman, Brooklyn.—p. 816.
Respiration in Infancy: II. Study of Rate, Volume and Character of Respiration in Healthy Infants During Neonatal Period. Jean Deming, San Francisco, and J. P. Hanner, Atlanta, Ga.—p. 823.

Blood Picture After Splenectomy in Children.—Wollstein and Kreidel performed splenectomy in forty-four children for traumatic rupture in three, rheumatic disease in twenty, splenomegaly of undetermined origin in one, congenital hemolytic icterus in four, Cooley's anemia in eight and hemorrhagic thrombocytopenia in eight. The ages of the children ranged from 11 months to 12 years and 11 months. When there had been no preoperative diminution in the number of platelets, as in cases of traumatic rupture, rheumatic disease and congenital hemolytic icterus, there was no immediate increase after the operation; but an increase appeared toward the middle or end of the first week, rarely before the third day. In cases of hemorrhagic thrombocytopenia, in which the number of platelets had been much diminished, splenectomy was followed by an immediate rise in all but one instance. This rise was not maintained in a fatal case and was delayed in the case of a boy who has lived two and one-half years after operation. The peak was reached, as a rule, in the second postoperative week, and a level of 1,000,000 platelets per cubic millimeter was maintained for a week or for several months. A fall in the reticulocyte count was characteristic of typical cases of congenital hemolytic icterus. In patients with Cooley's anemia, the response of the platelets was most irregular in onset, number and duration of the increase, and it was never as high or of as long duration as in the other groups. Increase in the number of nucleated red cells is characteristic in these cases. Operations other than splenectomy were not followed by any appreciable rise in the platelet count during the postoperative period of observation. None of the four control children showed an appreciable rise in the platelet count during the postoperative (nephrectomy, nephropexy and ureterotomy, exploratory laparotomy and herniorrhaphy) period of hospitalization or during the two months following discharge.

Rapid Typing of Pneumococci.—Vinograd and her collaborators compared the results of typing pneumococci from laryngeal swabs obtained from children and infants by the Neufeld technic with those obtained by inoculation of a mouse, using microscopic and macroscopic agglutination technics and examination of blood agar plates streaked with the original material. For the Neufeld procedure, the tube of broth containing the original material was centrifugated at high speed for from five to ten minutes to sediment the particles of sputum, pus cells and organisms. All but 1 or 2 drops of the supernatant fluid was decanted and retained for further use. A loopful of the sediment was mixed on a cover slip with two or three loopfuls of type-specific rabbit serum and a loopful of Löffler's alkaline methylene blue. The preparation was then examined as a hanging drop under oil for the swelling phenomenon. To facilitate typing, preliminary tests were made with grouped serums by both the Neufeld reaction and the microscopic slide agglutination method. Last, a dilution streaking was made of the original specimen on a blood agar plate to indicate the kind and also the approximate number of organisms present. The Neufeld reaction gave positive results for 100 of 106 patients. The results were called positive in the sense that either a type of pneumococcus was identified directly by the Neufeld reaction or pneumococci were not obtained by any method. The majority of results showed a high degree of correlation between the Neufeld test and the other methods of typing. By most of the methods a specific type of pneumococcus was determined. There were seven patients from whom type-specific pneumococci were obtained only by direct typing by means of the swelling phenomenon, the methods of inoculation of a mouse and the plate method revealing no pneumococci. In only six cases in which other methods disclosed a specific type did the Neufeld reaction fail to indicate a type. Direct typing by the Neufeld method has the advantage of speed over other methods by shortening the interval of typing from approximately six to twelve hours in a large proportion of cases in children to less than one hour.

American Journal of Medical Technology, Detroit

2: 81-120 (May) 1936

*Laboratory Findings in Leukemic States. R. R. Kracke and Hortense Garver, Emory University, Ga.—p. 81.
Spirochaeta from Blood and Tissue Cultures of Diseased Chickens. E. Redowitz, Philadelphia.—p. 92.
Pathogenic Fungi: Studies from Two Fatal Cases. Fanny Bell Warnock, Champaign, Ill.—p. 98.
Cytology of Spinal Fluid. Phyllis Stanley, Newark, N. J.—p. 106.

Laboratory Observations in Leukemic States.—Kracke and Garver point out that recent research indicates that in leukemias of all forms heterophile antibodies are either absent or are found in low titers (generally but not necessarily below the normal level). This facilitates the differential diagnosis between certain forms of leukemia and infectious mononucleosis, which in the early stages are often clinically and hematologically identical. Leukemia may be excluded, but a low titer does not establish its existence. A titer of 1:128 in the absence of recent horse serum therapy and in the presence of suggestive symptoms almost invariably establishes the diagnosis of infectious mononucleosis. A titer above 1:128 is considered positive for this disease even if there is a history of serum injections, unless the patient has serum sickness (urticaria) at the time of examination or has only recently recovered from this condition. In severe cases the titer may reach

1 : 4,000. In a leukemia with a low cell count it is most important to be able to recognize the immature, blast forms and not confuse them with lymphocytes. The laboratory aids to this end should include careful morphologic study, peroxidase reactions, indophenol blue synthesis and studies on concentrated specimens of blood. The diagnosis of leukemia should never be made in a laboratory. This can be done only by the physician.

American Journal of Psychiatry, New York

92: 1007-1246 (March) 1936

Experimental Approach to Psychiatry. W. H. Gantt, Baltimore.—p. 1007.
Psychiatry In and Around St. Louis. L. B. Alford, St. Louis.—p. 1023.
Relation of Trauma to Mental Diseases. A. Myerson, Boston.—p. 1031.
Remarks Concerning Development of Applied Psychopathology. E. Stransky, Vienna, Austria.—p. 1043.
Bodily Organs and Psychopathology. S. E. Jelliffe, New York.—p. 1051.
Psychic Trauma in Etiology of Graves' Disease: Survey of Five Thousand Case Histories. I. Bram, Philadelphia.—p. 1077.
Problems of Convalescence and Chronic Illness: Preliminary Discussion. H. F. Dunbar, New York.—p. 1095.
Dante Gabriel Rossetti: Case: Psychologic Study of a Chloral Addict. L. J. Bragman, Binghamton, N. Y.—p. 1111.
Blood Fat Iodine Number: Presenting Experimental Basis for an Exact Differential Diagnostic Procedure. A. T. Brice, Palo Alto, Calif.—p. 1123.
Anticipations and Corroborations of Freudian Concepts from Nonanalytic Sources. A. A. Brill, New York.—p. 1127.
Neymann-Kohlstedt Diagnostic Test for Introversion-Extroversion as Applied to Delinquents. M. J. Pescor, Lewisburg, Pa.—p. 1137.
Fundamental Effects of Epileptogenous Agents on Central Nervous System. E. A. Spiegel and M. Spiegel-Adolf, Philadelphia.—p. 1145.
Functional Psychoses in Children: Analysis of Findings in Twenty Cases of Psychotic Children Studied at the Child Guidance Home. L. A. Lurie, Esther B. Tietz and J. Hertzman, Cincinnati.—p. 1169.
Heat Regulation in Dementia Praecox: Reactions of Patients with Dementia Praecox to Cold (Résumé of Findings). I. Finkelman and W. Mary Stephens, Elgin, Ill.—p. 1185.
Allergic Reactions in Mental Diseases. J. A. Beauchemin, Middletown, Conn.—p. 1191.
Psychotherapy of Adolescents. Florence Powdermaker, New York.—p. 1205.

Journal of Thoracic Surgery, St. Louis

5: 337-452 (April) 1936

*Management of Bilateral Cavernous Pulmonary Tuberculosis: Bilateral Caseous Pneumonic Pulmonary Tuberculosis. P. N. Coryllos and G. G. Ornstein, New York.—p. 337.
Artificial Respiration by an Apparatus Which Permits Measured and Controlled Volumes and Pressures. W. Branower, New York.—p. 377.
*Vagus and Its Relation to Surgery of Lung. L. O'Shaughnessy, London, England.—p. 386.
Acute Empyema Thoracis: Study of Healing and Pulmonary Reexpansion. H. A. Carlson, Minneapolis.—p. 393.
Diaphragmatic Hernia in Infants Under One Year of Age Treated by Operation. T. G. Orr and F. C. Neff, Kansas City, Kan.—p. 434.
Tuberculous Tracheobronchitis: Report of Case. P. D. Crimm and J. W. Strayer, Evansville, Ind.—p. 441.
New Thoracoplasty Screen. W. D. Thompson Jr., St. Louis.—p. 444.

Management of Bilateral Cavernous Tuberculosis.—Coryllos and Ornstein believe that no bilateral case should be considered hopeless and unsuitable for collapse treatment because of the fact alone that it is bilateral; even if only one lobe is still healthy, treatment should be instituted. In 238 cases of bilateral pulmonary ulcerative tuberculosis they could not induce pneumothorax or the cavities could not be collapsed because of the presence of adhesions. The additional application of intrapleural pneumonolysis and thoracoplasty was considered. The results obtained show that from 40 to 60 per cent of these patients, thus far considered hopeless, can be rescued and their sputums rendered persistently bacillus free. The severe restrictions for surgical treatment commonly applied today to these patients are not justified. Evidence is presented in favor of the conception that no case should be considered hopeless only because it is bilateral, even when bilateral pneumothorax did not succeed in collapsing the cavities. The importance of a modified technic of closed pneumonolysis is stressed and the efficiency of bilateral thoracoplasty in selected cases is insisted on. The surprisingly small amount of healthy pulmonary parenchyma necessary for continuation of moderately active life was a great aid in allowing the authors to collapse large areas of diseased lung successfully.

The Vagus and Its Relation to Surgery of Lung.—In the course of his experiments on laboratory animals on the relation of the vagus to lung surgery, O'Shaughnessy also made observations on the sensitivity of the lung root in man. During an intervention on the thoracic esophagus, a patient whose general condition had remained good despite a wide exposure of the mediastinum manifested great distress as a separation of the esophagus from the left main bronchus was attempted. As soon as the attempt was abandoned the general condition returned to its former state, and recovery from the exploration was uneventful. In three cases the lung root was explored and a ligation of the pulmonary vein after the manner of Kerschner carried out. No cardiac or respiratory distress was observed except in one case, in which retraction of the heart by the hand of the assistant produced a marked but temporary bradycardia. In these cases a swab soaked in 15 per cent cocaine was applied to the area without harmful effects, but, in view of the author's experimental observations, some other method of local anesthesia will be adopted. During an operation for the open division of adhesions between the lung and the thoracic wall, the patient being anesthetized by N-methylcyclohexemylmethylmalonylurea, he had occasion to observe that the region of the lung root was highly sensitive. The vagus is an important sensory nerve, and it is an advantage to prevent nociceptive impulses from passing along it. At the same time, blocking of the vagus stem is not a safeguard against reflex disturbances while operating in especially sensitive regions, such as the lung root; respiratory reflexes are certainly abolished, but cardiovascular reflexes remain. Safety can be attained only by a local infiltration of the operative field. Total spinal anesthesia in man proved a satisfactory anesthetic for some operations on the chest wall, such as thoracoplasty, but it was not used in any operation on the lung. Experimental results suggest the trial of total spinal anesthesia for intrathoracic operations.

Maine Medical Journal, Portland

27: 63-82 (April) 1936

Ectopic Pregnancy, with Analysis of Thirty-Eight Cases Occurring at the Maine General Hospital During Past Six Years. W. F. W. Hay, Portland.—p. 67.
*Auricular Fibrillation Associated with Apoplexy. O. C. Perkins, Brooklyn.—p. 70.
The First Mate's Yarn About Bosun's Patient, Told by Him to the Surgeon in the Sick-Bay of the S. S. "Dartagnan." S. P. Warren, Portland.—p. 74.
The Physician in National Defense. G. M. Ekwurzel, Boston.—p. 75.

Auricular Fibrillation Associated with Apoplexy.—In a study of more than 1,000 cases of apoplexy Perkins observed that one out of every eleven admitted to the hospital had auricular fibrillation. Although many of these patients had been treated previously for heart disease or hypertension, it was quite impossible to determine the status of the cardiac condition just prior to the cerebrovascular accident. Early in the intensive study of patients with apoplexy it was noted that in many instances the auricular fibrillation disappeared before digitalization was attempted. In five cases of hemiplegia, a careful history showed that the acute onset was typical of coronary thrombosis. There was a complete necropsy performed in three of the cases in which death occurred from coronary thrombosis. The cerebral condition was typical of embolism, involving branches of the middle cerebral artery. In the cases of cerebral infarction from embolism due to intracardiac thrombosis, it is difficult to determine the origin of the embolus, when auricular fibrillation is present. No one condition or single set of circumstances can explain the development of auricular fibrillation in all cases. Three possibilities are suggested: (1) disruption of the normal processes of conduction within the auricles as a result of some pathologic change in the muscle fibers, (2) alterations in the metabolic activities of the heart and (3) alterations in the nervous influences, especially conditions of increased vagal tone. Any one or all three elements may be responsible in a given case. These patients generally belong to one of the following groups: the chronic cardiovascular-renal type, generalized arteriosclerosis or senile heart of the paroxysmal type associated with hypertension. If a careful history of the onset of the vascular accident is obtained, it is noted that it occurred during physical activity or exertion, a condition which favors an increase in the cardiac arrhythmia and predisposes to embolism instead of thrombosis. The clini-

cal picture presented by the patient is that of an infarction rather than hemorrhage. The immediate care of these patients should be placed in the hands of the internist, as the problem of greatest importance is the treatment of the crippled heart. The repair of the cerebral infarction as well as the favorable prognosis depends on the improvement in the general circulation, which is governed by the cardiac status. When the patient has improved sufficiently to be discharged from the hospital, he should be instructed as to the importance of the observation and care of his cardiac condition in order to prevent, as far as possible, its recurrence.

Medical Annals of District of Columbia, Washington

5: 89-122 (April) 1936

Malignant Diphtheria: Report of Eight Cases Terminating in Death and One Case Treated Early and Efficiently with Recovery: Plea for Efforts Toward Prophylaxis, Early Diagnosis and Adequate Treatment. D. L. Weinstein, Washington.—p. 89.

Certain Clinical Aspects of Vitamin B Deficiency. G. L. Weller Jr., Washington.—p. 93.

Proctoscopic Findings in Ulcerative Lesions of Rectum and Pelvic Colon. G. W. Ault, Washington.—p. 96.

Fundamentals of Internal Medicine: Diseases of Nervous System. A. Schneider, Washington.—p. 101.

New England Journal of Medicine, Boston

214: 763-814 (April 16) 1936

Progress in Recognition of Congenital Heart Disease. S. McGinn and P. D. White, Boston.—p. 763.

Increase in Coronary Disease and Its Cause. F. P. Denny, Brookline, Mass.—p. 769.

Clinical and Pathologic Study of One Hundred and Fifty Cases of Tubal Pregnancy. B. Tenney Jr., Boston.—p. 773.

Congenital Absence of Vermiform Appendix in a Patient with Mental Disease. L. W. Darrah, East Gardner, Mass.—p. 776.

Occurrence of Allergic Reactions in Arthritic Patients. A. G. Young, Boston.—p. 779.

*Congo Red for Control of Bleeding. R. C. Graves and C. J. E. Kickham, Boston.—p. 782.

Method of Applying Temporary Adhesive Support to the Back. T. H. Peterson, Boston.—p. 783.

New Instrument: An Antiadhesion Pneumothorax Needle. C. Floyd, Boston.—p. 785.

Congo Red for Control of Bleeding.—Graves and Kickham call attention to the use of congo red as a hemostatic agent. They have employed it for the relief of bleeding in renal injury, bilateral renal and ureteral calculi, chronic pyelonephritis, vesical calculus, benign hypertrophy of the prostate, tumor of the bladder, urethral trauma and the like. There have been no untoward effects in any instance, following the injection of 5 cc. of congo red (1 ampule of a sterile isotonic solution) or 10 cc. given intravenously. This may be repeated if necessary. Rossak states that occasionally patients complain of palpitation and lower abdominal pain, but the authors have not observed such disturbances. Even the accidental paravenous injection of the dye has resulted in no ill effect other than a persistent red discoloration of the skin. Congo red has been found to be most useful in cases of acute bleeding in individuals who still possess at least a relatively normal coagulation mechanism, and less effective in such chronic persistent bleeding as often occurs from pyelonephritis or malignant tumors of the urinary bladder. Whether its lack of success under such circumstances is due to local or general causes is not known. Obviously it will be of little or no value in actual blood disease. The authors have used it as a prophylactic agent following prostatectomy and transurethral resection, when unusual bleeding has been encountered. Some of their colleagues have administered it with marked success in severe epistaxis and hemorrhage after tooth extraction.

New Jersey Medical Society Journal, Trenton

33: 187-244 (April) 1936

Acute Hematogenous Osteomyelitis. B. F. Buzby, Camden.—p. 193.

Clinical Interpretation of Jaundice. V. Knapp, Asbury Park.—p. 202.

Prophylaxis of Communicable Diseases. M. L. Ripps, Elizabeth.—p. 205.

*Cardiac Dyspnea: Its Early Treatment with Mercurial Diuretics. L. Levin, Trenton.—p. 208.

Cardiac Dyspnea.—Levin points out that, since failure of the left side of the heart with its dyspnea, râles and dulness is nothing more than an obvious dropsy of the lungs (water retention), its proper treatment should include the use of diuretics. Because results have not been consistent with the use of oral diuretics, he has recently been using salyrgan and, to a lesser extent, mercupurin (the sodium salt of trimethyl-cyclopentane-dicarbonic acid-methoxy-mercury-allylamide-theophylline) intramuscularly. The use of mercurial diuretics is indicated in early left ventricular failure when the signs and symptoms continue after a reasonably short period of rest and digitalis therapy, and, if urine output continues to fall much below liquid intake in spite of thorough digitalization, the patient is headed for generalized failure. The contraindications may be said to be renal and gastro-intestinal. Severe nephritis is a definite contraindication. The intravenous use of salyrgan or mercupurin is almost impossible when mercurial diuretics are required over a period of months or longer; therefore the intramuscular route has been chosen as best fitted to meet the therapeutic requirements of most patients. The anterolateral aspect of the thigh rather than the gluteal region is the site of choice, particularly in a bedridden patient. An injection of 1 cc. is followed on the third day by 2 cc., provided no gastrointestinal or renal dysfunction develops. This dosage is maintained only as long as it remains effective. When it is noted over a period of from two to four days that the net water balance is unfavorable, the dosage is raised to 4 cc. The frequency with which injections are repeated depends on the status of the water metabolism. The patient is asked to chart his liquid intake and output. The former is usually limited to not more than 1,500 cc. When the level of the urinary output falls below the intake, another mercurial injection is needed. The measurements are continuous and give the clue to each succeeding treatment. Gradually, in favorable cases, the interval between injections increases as the efficiency of the kidney improves. A maintenance dose of 4 cc. once a month is generally sufficient to keep the heart well compensated. In most cases it has been deemed unwise to risk a relapse by ceasing entirely the use of the diuretic. The prolonged use of acid salts as an adjunct in the diuretic treatment of left ventricular failure has not proved satisfactory. The use of from 6 to 10 Gm. of an ammonium salt soon renders all food unpalatable and may produce nausea and vomiting. The additional quantity of urine excreted by the use of these salts has not been significant enough to warrant their routine use.

Northwest Medicine, Seattle

35: 119-162 (April) 1936

Specific Immunization in Treatment of Chronic Infections. M. J. Fuendeling, Twin Falls, Idaho.—p. 119.

Influence of Modern Psychiatry on Medical Thought: Psychobiologic Interpretation of Neurovegetative Syndromes with Presentation of Case Material. A. W. Hackfield, Seattle.—p. 127.

Exposure of Infants to Tuberculosis and Tuberculin Test. J. A. Myers, Minneapolis.—p. 134.

Physical Examination of Chest. G. Van Scoyoc, Los Angeles.—p. 137.

Common Forms of Heart Disease: Their Recognition and Treatment. W. H. Holmes, Chicago.—p. 142.

Lymphogranuloma Inguinale. W. R. Jones, Seattle.—p. 148.

Local Anesthesia in Obstetrics. F. J. A. Ditter, Yakima, Wash.—p. 150.

Pennsylvania Medical Journal, Harrisburg

39: 473-560 (April) 1936

Recent Advances in Surgery of Pancreas. A. O. Whipple, New York.—p. 473.

Pancreatic Enzyme Studies: Comparison of Some Methods of Trypsin Estimation. M. I. Stein, Harrisburg.—p. 478.

*Rôle of Infection and of Disturbed Cholesterol Metabolism in Gallstone Genesis. H. L. Bockus, J. H. Willard and H. N. Metzger, Philadelphia.—p. 482.

Indications for Surgery in Gallbladder Disease. D. B. Pfeiffer, Philadelphia.—p. 489.

Diagnosis of Neurogenic Bladder by Means of Cystometer. M. Muschat, Philadelphia.—p. 493.

Etiology, Diagnosis and Treatment of Hydronephrosis. J. C. Birdsall, Philadelphia.—p. 497.

The Genesis of Gallstones.—Bockus and his associates analyzed the clinical and laboratory data that could be considered pertinent to the genesis of the common types of calculi in 156 cases of proved gallstone disease. The cases have been segregated into three groups, depending on stone types: pure

radiate cholesterol stones, calcium bilirubinate-cholesterol (mixed) stones and pigment stones. A comparison has been made between the observations in the first two groups, particular attention being paid to an analysis of factors bearing on infection and disturbed cholesterol metabolism in gallstone genesis. It is concluded that gallbladder infection and cholecystitis probably do not play an important part in the genesis of the common mixed stone. Associated infection is more commonly observed in the calcium bilirubinate-cholesterol stone group than in cases of the pure radiate cholesterol stone. Evidence is given which suggests that the concomitant inflammation of the gallbladder so frequently encountered results from rather than causes the deposition of stones. A mobilization of all available information fails to establish the mechanism by which a disturbance of cholesterol metabolism is responsible for the deposition of cholecystic calculi. However, the data submitted suggest that an alteration in cholesterol metabolism plays an important part in the genesis of both the pure cholesterol and the ordinary mixed gallstone.

Public Health Reports, Washington, D. C.

51: 411-442 (April 10) 1936

History and Study of Leprosy in Hawaii. C. H. Binford.—p. 415.
Dermatitis from Wrist-Watch Straps. L. Schwartz.—p. 423.
Ornithodoros Parkeri, a New Species of Rodents. R. A. Cooley.—p. 431.

51: 443-492 (April 17) 1936

History and Frequency of Smallpox Vaccinations and Cases in Nine Thousand Families: Based on Nation-Wide Periodic Canvasses, 1928-1931. S. D. Collins.—p. 443.

Southern Surgeon, Atlanta, Ga.

5: 91-176 (April) 1936

Ocular Manifestations of Intracranial Tumors. A. C. Woods, Baltimore.—p. 91.
Secondary Inguinal Hernia with Bilateral Indirect Inguinal Hernia. J. Venable and H. Blincoe, Emory University, Ga.—p. 115.
Surgical Treatment of Duodenal Lesions. J. S. Horsley, Richmond, Va.—p. 120.
Common Bile Duct Obstructions. J. D. Highsmith, Fayetteville, N. C.—p. 130.
*Surgical Measures for Prevention of Gas Gangrene. G. A. Caldwell, Shreveport, La.—p. 141.
Edmund Strudwick, Surgeon. H. A. Royster, Raleigh, N. C.—p. 153.

Surgical Measures for Prevention of Gas Gangrene.—During the last two years at the Shreveport Charity Hospital and in his private work, Caldwell has encountered nineteen cases of gas gangrene of the extremities with ten deaths. The nine patients who lived escaped death only by the sacrifice of limbs. A careful review of the case records reveals the probability that, with proper management, eight of the ten deaths might have been prevented and six of the nine amputations might have been avoided. This mortality rate, compared with 48.5 per cent during the World War and from 7 to 32 per cent as shown by several reports during recent years in civil practice, indicates that some fundamental surgical principle is being violated. Correct surgical principles for the prevention and control of gas gangrene were carefully worked out during the World War, and these have not changed. The whole difficulty is that these principles have been forgotten or that a new generation of surgeons has grown up who are not sufficiently impressed with their importance. In discussing the surgical measures for the prevention and treatment of gas gangrene, the author reviews briefly the bacteriology and pathology of the disease. Thorough exposure and removal of all damaged muscular tissue rob the bacillus of its culture mediums and, if the wounds are left wide open, such anaerobes as may remain cannot gain a foothold because of the presence of oxygen. The author states that, had these measures been faithfully applied in the nineteen cases presented, the deaths might have been reduced to two or less, and the amputations to at least three on the patients who recovered. Instead, however, the débridements almost invariably were followed by suture of the wounds with subsequent development of gas gangrene, and the amputated stumps were closed with fatal results. Perfringens antitoxin is a valuable prophylactic and therapeutic adjunct but in no way displaces proper surgical measures.

Texas State Journal of Medicine, Fort Worth

31: 735-808 (April) 1936

Diagnosis of Early Syphilis. W. Spiller, Galveston.—p. 740.
Treatment of Syphilis. S. Cooper, Abilene.—p. 742.
Preventive Measures Against Syphilis. J. W. Bass, Dallas.—p. 745.
Malaria Treatment of Paretic Cases. T. H. Cheavens, Dallas.—p. 747.
Diagnosis and Treatment of Persistent Occipitoposterior Positions. E. L. King, New Orleans.—p. 751.
*Massive Abdominal Hemorrhage from Ruptured Corpus Luteum Cyst. E. Jones, Wichita Falls.—p. 755.
Filtration at Different Depths for Maximal Effects in Roentgen Therapy. R. G. Giles, Temple.—p. 757.

Hemorrhage from Ruptured Corpus Luteum Cyst.—Jones reports three cases of massive abdominal hemorrhage from ruptured corpus luteum cyst. In each instance there was excruciating pain in the lower part of the abdomen near the midline. This pain lasted from two to twenty minutes and then was followed by from thirty minutes to one hour of complete absence of any symptoms at all. Then followed, in regular sequence, first a generalized tenderness in the lower part of the abdomen, next a rigidity of the muscles more marked on the affected side, next abdominal distention, and then the usual symptoms of shock, which follow hemorrhages. There was no nausea or vomiting until hypodermics were used, but two authors report the presence of nausea. The cervix appeared to be normal; the uterus was normal in size and freely movable; in the tubo-ovarian areas there seemed to be some tenseness but very little resistance and no distinct tender areas. The accompanying pressure on the abdominal wall seemed to elicit far more tenderness than the vaginal observations justified. The abdomen presented rigidity of the muscles, distention, first confined to the area below the umbilicus and later to the upper part of the abdomen. There was a dull flat note on percussion. The blue umbilicus was not noticed. The general symptoms, such as fainting, pallor, sweating and rapid pulse, are the usual chain seen in hemorrhagic shock. The differential diagnosis brings to mind (1) ectopic pregnancy, (2) appendicitis, (3) traumatic rupture of a viscus and (4), in one case, ruptured gallbladder. It would seem that appendicitis could be ruled out and possibly traumatic rupture, and it truly seems that the confusion with gallbladder disease would be far fetched in most cases, but the author does not see how the possibility of ectopic pregnancy could be excluded before operation. There is little need for a differential diagnosis between these two entities, as the operative indication is the same. The patients' ages were 22, 24 and 28. Not more than six hours elapsed from the onset of the first symptom to the time of operation in two of the cases, yet there was more than three pints of liquid blood and half that much of clotted blood in the abdomen in each case. None of the patients gave a history of any serious menstrual disorders. The hemorrhages occurred at various times during the menstrual month: one, five days after a normal period; one, sixteen days, and the third, twenty-one days. The main point in diagnosis is that, if a case presents many of the symptoms of an ectopic pregnancy but the classic bulging mass is absent on vaginal examination, it should be remembered that massive hemorrhage can occur from a graafian follicle or a corpus luteum cyst, and immediate steps should be taken to handle the case as one of abdominal hemorrhage from any cause.

Virginia Medical Monthly, Richmond

63: 65-130 (May) 1936

Cancer Control. W. Clarkson and A. Barker, Petersburg.—p. 65.
Factors in Maternal Mortality. T. J. Williams, University.—p. 68.
Remarks on Diagnosis of Coronary Thrombosis. B. P. Seward, Roanoke.—p. 74.
Cesarean Section in Richmond, Va. H. H. Ware Jr., Richmond.—p. 82.
Diagnosis of Early Syphilis. E. E. Barksdale and D. C. Smith, Charlottesville.—p. 87.
Thyroid Control in Cardiac Therapy. C. Smink, Baltimore.—p. 91.
Vascular Surgery Necessitated by Trauma. J. L. Rawls, Norfolk.—p. 94.
Acute Small Bowel Obstruction: Study of One Hundred Cases. H. J. Warthen, Richmond.—p. 99.
Dermatoses and Cold Weather. R. Kimbrough, Norfolk.—p. 104.
Very Satisfactory Operation for Pterygium. N. H. Turner, Richmond.—p. 106.
Neisserian Smears from Prostate and Seminal Vesicles: Final Report. W. M. Bowman, Petersburg.—p. 107.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Physical Medicine, London

10: 205-226 (April) 1936

Brief History of Electrotherapy. W. J. Turrell.—p. 207.
Heliotherapy and Actinotherapy: Past, Present and Future. A. P. Cawadias.—p. 211.
Infra-Red Radiation in General Practice. W. A. Troup.—p. 215.
Rôle of Electricity in Therapeutics. E. P. Cumberbatch.—p. 216.
Treatment by Heat: Natural and Artificial Sources. M. B. Ray.—p. 219.
Review of Electromedical Apparatus. B. D. H. Watters.—p. 222.

British Medical Journal, London

1: 625-678 (March 28) 1936

Some New Drugs and Remedies. E. W. Adams.—p. 625.
Erythrocyanosis. E. D. Telford and H. T. Simmons.—p. 629.
The Problem of Suicide. C. S. Read.—p. 631.
Trachomatous Conjunctivitis. A. F. MacCallan.—p. 635.
Spontaneous Hematoma of Abdominal Wall. R. Mailer.—p. 637.
Rat-Bite Fever from a Kitten. A. F. Cole.—p. 638.
Rat-Bite Fever from a Cat. J. V. Laverick.—p. 639.

Journal of Laryngology and Otology, London

51: 141-212 (March) 1936

Some Impressions That Remain. A. L. Turner.—p. 141.
Some Remarks on Gradenigo's Syndrome and Petrositis (Including Consideration of Nine Cases and an Analysis of Seventy-Eight Recorded Cases). R. B. Lumsden.—p. 150.

Lancet, London

1: 643-700 (March 21) 1936

Medical Problems in Mineral Metabolism. R. A. McCance.—p. 643.
*Virus Etiology of One Form of Lymphocytic Meningitis. G. M. Findlay, N. S. Alcock and Ruby O. Stern.—p. 650.
Idiopathic Dilatation of Stenson's Duct. R. T. Payne.—p. 655.
Primary Intrahepatic Carcinoma of Bile Ducts. R. Binning.—p. 656.
Fistula in Ano. J. P. Lockhart-Mummery.—p. 657.
Case Showing an Unusual Relationship Between Asthma and Epilepsy. Kathleen Costello and J. T. Fox.—p. 660.

Virus Etiology of Lymphocytic Meningitis. — Findlay and his associates isolated a virus from the cerebrospinal fluid of two patients suffering from obscure nervous symptoms associated with an increase of lymphocytes in the cerebrospinal fluid. The virus inoculated intracerebrally into monkeys, mice, rats and guinea-pigs causes a fatal infection: post mortem there is intense infiltration of the meninges, choroid plexus and ventricles with round cells. When inoculated intraperitoneally into mice, the virus causes no symptoms but remains for some weeks in the spleen and kidneys. It is excreted in the urine of mice and can pass through the lightly scarified skin. A similar virus has been isolated from apparently healthy mice. The human and mouse strains isolated in this country behave in animals in the same way as the American virus described by Armstrong. Serums from human cases in this country contain immune bodies to the American virus and to the English mouse strain virus. There is thus evidence that this virus infection is widely spread on both sides of the Atlantic. The evidence here brought forward shows that a virus infection is present in mice and possibly also in rats and that this virus can be communicated to man. The exact port of entry in human cases has not yet been determined, but judging from analogies with infection by Leptospira icterohaemorrhagiae it is likely to be the skin or mucous membranes.

Medical Journal of Australia, Sydney

1: 351-384 (March 14) 1936

Recent Progress in the Art and Science of Medicine. L. J. J. Nye.—p. 351.
*Control of Bleeding in Nose and Throat Operations. R. G. Brown.—p. 359.
Laboratory Investigation of Suspected Psittacosis. F. M. Burnet.—p. 363.

Control of Bleeding in Nose and Throat Operations.—Brown discusses the physiology of blood coagulation and the theoretical methods of its control. Accepting a prothrombin deficiency as the causal factor in hemophilia, the various lines of treatment of deficiency in blood coagulation fall into three groups: (1) the introduction of normal prothrombin from some foreign source, (2) the introduction of any of the other coagulative elements, thus increasing the coagulability by the law of mass action, and (3) the introduction of some foreign substance in the hope of stimulating more rapid coagulation. Some of the most commonly used coagulating substances are discussed. The blood clotting time may be estimated in one of several ways, and the method selected is not so important as one's familiarity with a particular method and the use of that method only. An average of five minutes is taken as a safety mark and may be considered normal. Perhaps the simplest method of estimation is by the capillary tube. The estimation of the bleeding time is of more value than the clotting time. Normally the bleeding time should be from two to three minutes. The author stresses three points which he feels are not as commonly recognized as their importance deserves: 1. Faulty technic is the commonest cause of postoperative bleeding. 2. Bleeding not infrequently appears coming from beneath a clot. It is essential to remove this clot before one can successfully deal with it. Removal of the clot by wiping off in bleeding from a tonsil bed or, in bleeding from a nose, by washing out the clot or sometimes by simply blowing out the clot, may cause cessation of bleeding by allowing clots to form in the ends of the bleeding vessels. 3. Placing the patient in an upright position after a nose or throat operation is a big factor in the prevention of bleeding from small veins, which are the vessels mainly responsible. In such a posture the patient's blood pressure may be decreased; the "tone" of the cut ends of the vessels is increased, thereby more readily aiding constriction. Moreover, there is less pressure of venous blood above the bleeding points.

Practitioner, London

136: 349-540 (April) 1936

Boils and Carbuncles. J. Fraser.—p. 350.
Infections of Face and Lips. P. H. Mitchiner.—p. 367.
Whitlows and Infections of the Hand and Fingers. N. C. Lake.—p. 376.
Modern Methods in Treatment of Burns. W. C. Wilson.—p. 394.
Infections of the Foot and Ingrowing Toenail. A. W. Kendall.—p. 404.
Minor Injuries to Muscles and Joints. W. E. Tucker.—p. 415.
*Sprains and Strains. C. B. Heald.—p. 422.
Minor Surgical Affections of Skin. A. D. Wright.—p. 429.
Minor Surgery of the Breast. R. M. Vick.—p. 438.
Minor Gynecologic Surgery. A. C. Bell.—p. 445.
Minor Surgery of Childhood. T. T. Higgins.—p. 454.
Short Anesthesia for Minor Surgery in Children. H. Sington.—p. 468.
Minor Injuries of Eye. F. W. Law.—p. 474.
Minor Oral Surgery. A. L. Spencer-Payne.—p. 484.
Traumatic Orchitis and Hematocele. G. E. Neligan.—p. 496.
Injection Treatment: Supplement to Surgery. D. Levi.—p. 500.
Local Anesthesia in Minor Surgery. A. L. Abel.—p. 509.
Favorite Prescriptions: XVI: The National Hospital for Nervous Diseases, Queen Square. D. Brinton.—p. 520.

Sprains and Strains.—Heald gives rules for the treatment of delayed recovery cases of strains and sprains. 1. Injured parts that are persistently painful on waking after they should normally be well, which ease up during the day, require general treatment or elimination of a focus of infection. 2. Injured parts worse on getting warm in bed and waking patients about 5 a. m. should be treated for gout, whatever the family history. 3. Injured parts that are free and painless at all times and with all movements except one have a critical adhesion and will repay mobilization. 4. Injured muscle groups that develop residual spots of pain, which on being touched radiate this pain, have an adhesion of a nerve, and only special technics, such as galvano-acupuncture, are of any use. 5. Parts remaining persistently thickened and boggy long after they should have recovered are suggestive of a gonococcic basis. The practitioner is urged therefore to give his sprains and strains, on the day of injury if possible, the simple direct current or to send the patient to the technician with a fully detailed prescription.

South African Medical Journal, Cape Town

10: 167-206 (March 14) 1936

Our Association. W. Russell.—p. 169.
Biblical Medicine. B. Weinbren.—p. 172.
Conservative Treatment of Intracranial Trauma. A. Radford.—p. 180.

10: 207-246 (March 28) 1936

Treatment of Acute Retention of Urine. V. Vermooten.—p. 209.
Some Aspects of the Native in Disease. L. S. Williams.—p. 213.
Disease in Non-European Patients. H. L. Heimann.—p. 215.
The Association in Natal. C. J. Albertyn.—p. 217.

Journal de Médecine de Lyon

17: 197-244 (March 20) 1936

Ophthalmoscopic Signs of Arterial Hypertension: Their Variations in Course of Evolution of "Hypertensive Disease." P. Bonnet and G. Bonamour.—p. 197.
Neuropapillitis from Neurotropic Virus. P. Bonnet, J. Dechaume, P. Wertheimer, L. Paufique and E. Blanc.—p. 213.
*Hyperthermic and Pallor Syndrome in Nurslings After an Operation. L. Genet.—p. 231.
Modern Operation for Cataract: Total Extraction of Crystalline Lens. P. Bonnet and L. Paufique.—p. 237.

Hyperthermic Syndrome in Nurslings.—Genet states that the so-called syndrome of hyperthermia and pallor is a rare but serious complication resulting from operations performed on infants. It is characterized by a progressive elevation of temperature, which develops five or six hours after the operation. The rise in temperature continues until it reaches 41 or 42 C. (105.8 or 107.6 F.) or even more and is accompanied by a marked pallor of the skin. Death may occur in less than thirty hours, but recovery is possible. The pathologic anatomy based on a few necropsies has revealed a constant sterility of blood and intact kidneys. There is, in fact, little that is abnormal in the pathology—nothing, in fact, to explain death. A probable pathogenesis is the irritation of the thermic centers, which are incompletely developed in the nursling. Such irritation is followed by a disturbance in the secretion or in the cycle of secretion of the cerebrospinal fluid at the level of the third ventricle. The medical treatment is to counteract the hyperthermia and to sustain the heart. Lumbar puncture has given good results in some instances.

Presse Médicale, Paris

44: 521-536 (March 28) 1936

Neutropism of Infectious Diseases. L. Rimbaud.—p. 521.
*Iliosacral Reticuloplasmocytomas. L. Sabadini, J. Montpellier and Chéchan.—p. 526.

Iliosacral Reticuloplasmocytomas.—Sabadini and his collaborators state that clinically the plasmocytoma at first invades the osseous medulla under the form of small tumors, which finally fuse. The invaded osseous tissue is quickly destroyed. Most frequently the tumors are multiple and distant from one another. The cranium may become perforated. In the vertebrae the plasmocytomas completely destroy one or more vertebrae and can invade the spinal canal. The onset is exceedingly insidious. Sometimes the tumor appears as a nodule about the size of a nut, an egg or a small mandarin. Occasionally the initial signs are facial paralysis or medullary compression. General examination of the patient is often negative. Examination of the urine is especially important in the diagnosis. In 80 per cent of their cases, Bence Jones protein is present. They conclude from their studies that the tumors are rare and that the origin of both the normal plasmocyte and plasma tumors is uncertain. In the case which they reported all the transition stages between the reticulocyte cell and the tumor-like plasmocyte were found. This naturally suggests the reticulocyte origin of these tumors. The matter, however, is not yet certain.

Schweizerische medizinische Wochenschrift, Basel

66: 393-412 (April 25) 1936

Tasks of Research on Climatic Conditions of Health Resorts in Switzerland. W. Mörikofer.—p. 393.
*Overestimation and Underestimation of High Mountains as Therapeutic Factor. R. Campbell.—p. 396.
*Morphologic Blood Changes After Physical Exertion in High Mountains. A. Jezler and A. Vischer.—p. 398.
Balneologic After-Treatment of Surgical and Internal Diseases. J. Weber.—p. 400.
Physical Therapy of Gastro-Intestinal Disturbances. H. Müller.—p. 404.
Investigations on Biologic Action of Small Quantities of Radioactive Emanations in Ground Air in Region of Orselina, Above Locarno. H. Bodmer.—p. 409.

Mountain Climate as Therapeutic Factor.—Campbell discusses the physiologic action which high altitude exerts on the organism of a person who is accustomed to low altitudes. He says that the change to high altitude results in a change of reaction. He thinks that a sojourn at a high altitude is desirable for all disorders in which a change of reaction is desirable. However, whether induced by medicaments, by balneologic or climatologic methods or by other modes of stimulation, this change in reaction requires certain reserve powers in the organism in order to be beneficial. Where such reserves are lacking, a favorable effect cannot be expected or the influence may even be harmful. Even the quiet sojourn in the high mountains makes greater demands on the organism of one accustomed to low altitudes. All life processes are intensified, a factor which, in case of reduced reactivity, may already have a curative effect. However, the high mountain climate should also increase the resistance by the systematic increase in exertion. Since the therapeutic effect of the high altitude climate is dependent on an adequate amount of reserves, it is contraindicated in decompensated circulatory disturbances and in states of extreme exhaustion of organic origin. However, the author denies that the high altitude climate is harmful for all patients with heart disease. Patients with compensated cardiac defects or with disorders of the cardiac muscle not only tolerate the high altitude climate but are favorably influenced by it. The intensification of the life processes at high altitudes occasionally intensifies formerly mild symptoms, so that obscure cases become suddenly clarified. Insufficient attention is given to the rôle of nicotine in acclimatization. He says that symptoms of nicotine poisoning develop more readily at high altitudes. He mentions that tuberculosis, bronchial asthma, neuroses, compensated circulatory disorders, hypertension, hypotension, mental exhaustion, and so on, are cured more rapidly than when the patient remains in low altitudes.

Blood Changes After Exertion at High Altitudes.—Jezler and Vischer studied the changes in the blood picture that appear after prolonged ski runs (from five to nine hours' duration) in the high mountains. They found that in general the changes in the white blood picture are not great. The increases never reach the values that are observed after prolonged ski runs at low altitudes. Erythropoiesis seems to be greatly influenced by exertion at high altitudes; however, the increase in mature erythrocytes is not proportional. The authors suggest that the increased functional requirements might reduce the life span of the erythrocytes. The specificity of the stimulus of high altitude is indicated by the number relations of the leukocytes, for here the reaction capacity seems to decrease with the higher altitude. In this connection, the authors cite other observers who observed entirely normal leukocyte values after exertions at altitudes of 6,000 and 7,400 meters.

Rivista di Pathologia e Clin. d. Tubercolosi, Bologna

10: 221-292 (April 30) 1936

*Monocyte-Lymphocyte Ratio in Pulmonary Tuberculosis. L. Bresci.—p. 221.
Pulmonary Moniliasis: Case. F. Balestrieri.—p. 229.
Pathogenesis of Tuberculous Hemoptysis from Clinical Point of View. I. Cornia.—p. 233.
Hematogenous Pulmonary Tuberculosis in Children and Adolescents. E. Filla.—p. 242.
Weltmann Reaction in Artificial Pneumothorax. Lydia Barsottelli and Dina Poggioni.—p. 257.
Artificial Pneumothorax in Dispensaries. G. Rambelli.—p. 264.

Monocyte-Lymphocyte Ratio in Pulmonary Tuberculosis.—Bresci aimed at verifying the conclusions previously reported as to the value of the monocyte-lymphocyte ratio in diagnosis and prognosis of pulmonary tuberculosis. He determined the monocyte-lymphocyte ratio in two groups of patients suffering from pulmonary tuberculosis of the benign and severe forms. The monocyte-lymphocyte ratio was low in the blood of patients of the first group at the first determination, and still lower at the following two determinations. The initial figures of the ratio never exceeded 0.4 in patients of this group. The ratio was high in the blood of patients of the second group at the first determination, and still higher at the following determination. The initial figures were never under 0.5. Figures as high as 2 and 2.75 were obtained in grave cases. The author says that his results confirm the statements previously made in the literature as to the existence of a direct relation between the tuberculous process and the evolution of the monocyte-lymphocyte ratio. The blood mirrors the histocytologic evolution of the tuberculous process with an increased monocytosis and a decreased lymphocytosis in grave cases and the opposite monocyte-lymphocyte proportion in benign cases. The author emphasizes the diagnostic and prognostic value of the monocyte-lymphocyte ratio and the advantage of this procedure over the separate counting of these cells.

Münchener medizinische Wochenschrift, Munich

83: 587-628 (April 10) 1936. Partial Index

*Cause of Death in Air Embolism. W. Pfanner.—p. 591.
"Relapses" After Treatment of Varicose Veins. A. Vossschulte.—p. 593.
*Is Traumatic Ossifying Myositis the Result of Accident or of Treatment? L. Böhler.—p. 594.
What Does Cod Liver Oil Bandage Accomplish in Cases of Emergency? P. Bosse.—p. 601.
Foot Blisters and Their Treatment. W. Barthel.—p. 603.
Contracture in Paralyses and Its Orthopedic Treatment. J. Schüller.—p. 606.

Cause of Death in Air Embolism.—Pfanner shows that, if air enters the heart and there comes in contact with blood, the rhythmic contractions of the heart beat the blood into foam. As the volume of the foam increases, the proper systolic contraction and evacuation of the heart become impossible. The heart can neither expel the foam nor compress it. Thus the heart has to handle a considerable excess load. The right side of the heart, with its relatively weak muscular apparatus, gradually weakens and death results from interruption of the circulation by paralysis of the right side of the heart.

Traumatic Ossifying Myositis After Dislocation of Elbow.—Böhler describes the history of a case of dislocation of the elbow that came under his observation four months after the injury. The elbow showed thickening and felt hard, and movement was greatly restricted. Roentgenoscopy disclosed extensive ossification in the region of the brachial and triceps muscles. The author asserts that he has seen many similar cases of dislocation of the elbow in which extensive ossification processes developed in muscles and ligaments. The after-treatment had been energetic in all these cases. He cites several authors who believe that ossifying myositis results from almost all dislocations of the elbow. In the author's own material of twenty-nine cases there were only three in which a mild form of ossifying myositis developed. He reduces the dislocation under local or general anesthesia by means of traction on the flexed elbow and then puts the arm into a plaster-of-paris cast reaching from the shoulder to the fingers. This cast is usually left on for three weeks. Immediately after the cast has been put on, active movements are made in the shoulder and finger joints. After the removal of the cast the elbow is always soft, whereas in case of massage treatment it is usually hard and thickened. The author advises that the after-treatment should consist only of active movements and that all other modes of treatment should be avoided. Two of his three patients in whom a slight ossifying myositis developed had been given massage treatment and the third patient had performed hard physical labor immediately after removal of the cast. The author observed ossifying myositis also in some cases in which the reduction had been done either in hyperextension or several days after the injury. The author concludes that the ossifying myositis after pure dislocations of the elbow which are at once carefully reduced is not a result of the injury but rather of a mode of treatment in which massages and passive movements are begun early.

83: 629-670 (April 17) 1936. Partial Index

New Investigations on Pathology of Liver. W. Nonnenbruch.—p. 629.
Course of Oxidation Processes in Animal Organism. F. Knoop.—p. 633.
Is There a Hematopoietic Center in the Brain? G. Denecke.—p. 636.
Histamine in Functional Examination of Lung. A. Heymer.—p. 638.
*Diagnosis of Multiple Myeloma with Aid of Sternal Puncture. H. Schulten.—p. 642.
Insulin Therapy of Schizophrenia. H. Strecker.—p. 649.

Diagnosis of Multiple Myeloma by Sternal Puncture.—Schulten reports the clinical histories of two patients with multiple myeloma in which the diagnosis was made possible by sternal puncture. After emphasizing the importance of sternal puncture in cases of this nature, he stresses that observation of the fresh smear discloses that the typical myeloma cells do not resemble the myelocytes or the myeloblasts. Moreover, he is convinced that they are not one of the links in the developmental chain of the myeloleukocytes, erythrocytes or megakaryocytes and that they are not reticular cells. At first sight the cells resemble most closely the plasma cells, except that they are larger, the plasma is not quite so strongly basophil and the perinuclear transparency, the wheel-spoke nucleus and the capacity to be stained by specific dyes are lacking. One who frequently inspects bone marrow pictures knows that such cells occur occasionally in healthy persons and in patients with other disorders. As a rule they are classified with the plasma cells. The author concedes that a similarity with the plasma cells cannot be denied, but he says that it has not been proved as yet whether a genetic relationship to the plasma cells exists. Until their origin has been explained, he advises the acceptance of Wallgren's suggestion to refer to them as "myeloma cells."

Wiener medizinische Wochenschrift, Vienna

86: 397-424 (April 11) 1936. Partial Index

*Lift Reaction as Aura in Tumor of Temporal Lobe. H. Hoff and O. Pötzl.—p. 397.
Question of Tonsils. F. Fremel.—p. 399.
Practical Hypocratism. B. Aschner.—p. 402.
Treatment of "Static Dynamic Decompensation" by "Pelvic Lever" (Scissors Lever Principle). M. Jungmann.—p. 406.
*Pulsation of Normal and Varicose Veins of Extremities and Its Diagnostic Significance. R. Teufl.—p. 407.

86: 425-452 (April 18) 1936. Partial Index

Use of Anesthetic Methods by Practitioner. G. Lotheissen.—p. 425.
Memorandum for Relatives of Diabetic Children. R. Priesel and R. Wagner.—p. 427.
Resuscitation With and Without Apparatus. H. Hans.—p. 429.
*Lift Reaction as Aura in Tumor of Temporal Lobe. H. Hoff and O. Pötzl.—p. 432.
*Pulsation of Normal and Varicose Veins of Extremities and Its Diagnostic Significance. R. Teufl.—p. 436.

86: 453-480 (April 25) 1936. Partial Index

Injurious Effects of Cosmetics. M. Oppenheim.—p. 453.
Treatment of Diabetes: Use of Insulin and Urgent Measures. H. Dibold.—p. 457.
*Lift Reaction as Aura in Tumor of Temporal Lobe. H. Hoff and O. Pötzl.—p. 461.

Lift Reaction as Aura in Tumor of Temporal Lobe.—Hoff and Pötzl report the history of a woman, aged 39, who seven years previously had had her first epileptic attack. After that she had epileptic attacks three or four times each year, but during the last year they had become more frequent. The woman stated that before these attacks she frequently has the feeling of increasing in size, as if her head would reach the ceiling; at other times she has the feeling of going up in an elevator, followed by a feeling of going down again. These two types of aura recurred alternately. During the last year the patient has had frequent attacks of headache in the occiput, also nausea and vomiting. The authors found a reddish tumor on the first temporal convolution, but, since its limits could not be defined, only a portion of it was extirpated. The patient died twelve hours later. The necropsy revealed an infiltrating glioma in the anterior end of the right temporal lobe. Analysis of the manifestations of the aura reveals that they are in accord with the stretching phases of the lift reaction in quadrupeds (described by Magnus); that is, they are a reaction of the semicircular canals to progressive movements. Thus the aura had the character of a supravestibular disturbance.

Pulsation of Veins of Extremities.—Teufl found that a retrograde pulsation, and one which is somewhat retarded in comparison with the arterial pulse, of the normal veins of the upper and of the varicose veins of the lower extremities is a regular occurrence in organic as well as in relative tricuspid insufficiency, which in turn is unusually frequent in cardiac decompensation. The analysis of the venous pulse of the extremities, which, if done in profile illumination, is more readily accomplished than the evaluation of the pulsation of the jugular vein, and which in many cases is easier and more reliable than the palpation of the pulse of the hepatic veins, by the demonstration of its constancy and of its undiminished intensity permits the diagnosis of organic tricuspid insufficiency, independent of the compensatory condition of the heart, whereas its disappearance during the subsidence of the decompensatory manifestations indicates a relative muscular tricuspid insufficiency. The constant venous pulse which varies in intensity is an unfavorable prognostic sign of relative insufficiency of the tricuspid valve, whenever the decompensation cannot be influenced. In cases in which organic tricuspid insufficiency has been demonstrated, the weakening of the venous pulse of the extremities is a sign that the cardiac action is becoming weaker and indicates an unfavorable prognosis. Isolated pul-

sation of the varicose veins, which is largely dependent on the intra-abdominal pressure, and the respiratory phenomena which show a paradoxical behavior for the veins of the upper half of the body and predominate over the pulsatory manifestations, even if the pulsation is retrograde and retarded, militate against a tricuspid insufficiency and are to be traced to a direct or indirect central involvement. The surprising contradiction between a clearly retrograde venous pulse in the region of the upper extremity and a nearly absent pulse of the varicose veins, in the presence of abdominal stasis, is an important argument in favor of the difficult diagnosis of concretion or accretion of the heart. The absence of the venous pulse in the extremities, in patients with severe cardiac insufficiency and peripheral stasis, disproves dilatation of the right side of the heart and suggests a mechanical throttling of the venae cavae, which in turn might be caused by a pericardial exudate or by a space limiting mediastinal process. The penetrating venous pulse is the result of an especially high pulse pressure and, as a rare occurrence in aortic insufficiency, it is without clinical significance; but the retrograde venous pulse of the extremities is of considerable significance.

Novyy Khirurgicheskiy Arkhiv, Dnepropetrovsk

35: 163-312 (No. 138) 1936. Partial Index

Organization of Campaign Against Cancer. A. A. Epshtein.—p. 163.
*Pathogenesis of Gynecomasty. D. G. Goldman.—p. 181.
*Results with Parathyroidectomy for Ankylosing Polyarthritis. P. S. Fedorov.—p. 208.
Cancer of Cystic Duct. I. P. Levanyuk.—p. 215.
Rabl Method of Treatment of Rachitic Deformities of the Lower Extremities. A. I. Kogon.—p. 222.
Prolonged Intravenous Drop Infusion. K. G. Tagibekov.—p. 235.

Pathogenesis of Gynecomasty. — Goldman has collected seventy-two cases of gynecomasty among patients treated from 1925 to 1935 at the marine hospital of Kronstadt. Operation was performed in sixty-eight of these cases. Enlargement of both breasts was present in twelve (16.7 per cent). Pressure on the glands yielded a secretion in eleven. Pathologic alterations in the sexual sphere were present in sixteen (22.2 per cent). A female type of distribution of the suprapubic hair and a wide pelvis was present in eleven. The development of the sexual organs was normal in all but ten cases. Sexual function was normal in all save three cases, in which libido was diminished in two and absent in one. Trauma of the breast was an etiologic factor in six. The reaction of Manoiloff was made in twenty-eight cases and was found to be of the female type in twenty-six. The author found in his animal experiments that castration of males (rabbits) followed by transplantation of ovaries (from rabbits) caused a hypertrophy of the mammary glands. Parenteral introduction of solution of posterior pituitary produced a hypertrophy of the mammary glands in rats and white mice. Injections of ovarian or mammary extracts had no such effect. The author is of the opinion that the existence of an internal secretion of the mammary gland has not been demonstrated. Histologic studies point to the breast as a gland of external secretion. The author concludes that gynecomasty is frequently unaccompanied by any abnormality in the sexual sphere. There may exist hyposexualism and hypothyroidism in a number of cases. Histologic studies reveal a well developed glandular apparatus but no secreting cells.

Parathyroidectomy in Ankylosing Polyarthritis. — Fedorov reports 121 parathyroidectomies performed at the Mechnikov Hospital (Leningrad) from 1926 to 1932. Oppel suggested in 1926 that ankylosing polyarthritis is a disease of infectious origin characterized by inflammatory changes of the synovial membrane and the surfaces of the bones of a joint. He found that the blood calcium of patients suffering from this form of polyarthritis is increased above the normal and that the calcium deposited on the inflamed joints led to ankylosis. The condition is one of hypercalcemia, the opposite of the one found in tetany, which is characterized by hypocalcemia. Oppel formulated the theory that hyperfunction of the parathyroid tissue was the basis of the condition. He performed parathyroidectomies and found that the muscular stiffness, joint stiffness and pain were relieved. The disease affects preponderantly young men between the ages of 20 and 40. There were only two women in this series. The disease is characterized by a progressive involvement of the joints, the vertebral column being the seat of predilection. The disease must be differentiated from deforming polyarthritis, in which ankylosis is due to exostoses of the vertebral bodies. The muscles become stiff and woodlike. Forty-eight patients of a group of ninety-three showed hypercalcemia. The immediate effects of the operation were the relief of pain and stiffness. This was observed in seventy-nine out of 121 cases. The operation advocated is a unilateral parathyroidectomy and hemistrumectomy. Eighty-four cases were followed up for periods ranging from three to seven years. Improvement was reported in thirty-nine, arrest of the process in nineteen and progression of the disease in seventeen. The best results were obtained in cases of pronounced hypercalcemia. There were no deaths due to tetany.

Finska Läkaresällskapets Handlingar, Helsingfors

79: 195-294 (March) 1936

*Studies on Granulocytopenia. B. von Bonsdorff.—p. 200.

Granulocytopenia. — Of von Bonsdorff's fifteen patients, four were men and eleven women, ranging in age between 18 and 67, the majority being between 40 and 50. Five of the cases were previously reported and ten are now presented. He says that nine cases were more or less probably the result of aminopyrine. In three of these, of which two were fatal, antisyphilitic treatment with neoarsphenamine and preparations of bismuth was probably the cause. In one the disorder is ascribed to roentgen treatment given for polyarthritis, and in two, one with chronic intermittent course, the other also with recurrence, the etiology is unknown. In several cases in which the disturbance lasted a long time there was in addition to the granulocytopenia a more or less marked anemia. Cytologic examination of the sternal marrow carried out in eight cases showed abundant myelocytes and myeloblasts in the three patients who recovered, while in three of the five fatal cases the picture was dominated by reticulo-endothelial cells, partly of plasma cell nature, and in two the punctate was deficient in cells and contained mainly lymphocytes, monocytes and erythroblasts. The outcome of the sternal puncture is of great value in judging the prognosis; the blood picture affords no certain guidance in this respect. One case was clinically regarded as "noma" and the author is of the opinion that the necrosis of skin and mucous membrane formerly connected with the conception of "noma" is mainly the result of a more or less marked reduction in granulocytopoiesis, and in certain cases with leukemic picture perhaps also to a qualitative deficiency in the granulocytes. The good results obtained in two of the earlier cases by energetic liver treatment were not duplicated in later advanced cases, but liver therapy still seems the most promising. He advises against roentgen therapy.

Hospitalstidende, Copenhagen

79: 325-368 (April 7) 1936

*Primary Cancer in Lung. E. Husted and Gerda Biilmann.—p. 325.
Polymorphic Prurigo Aestivalis Treated with Intravenous Injections of Gold Chloride. S. Lomholt.—p. 353.
Acute Myeloblastic Leukoses: Two Cases. H. C. and R. Rask-Nielsen. —p. 360.

Primary Cancer of Lung.—Husted and Biilmann's material comprises forty-one cases, from 1911 to 1934. From 1924 on they find an absolute and a relative increase in the number of patients with primary pulmonary cancer; from 1929 to 1933 pulmonary cancer appeared in between 1 and 2 per cent of all necropsies and in 7.3 per cent of all cancer cases. The etiology is uncertain. Two cancers developed in patients with chronic inflammations of the lungs. No relation was demonstrable between the frequency of pulmonary cancer and the more extensive tarring of roads. The disorder may be latent a long time, and in about one fourth of the cases pulmonary symptoms were absent. Only about one third were diagnosed during life. The authors emphasize the importance of roentgen examination, particularly supplemented by bronchography. The primary tumor is almost always found centrally in the lung in close relation to the bronchi, and the large majority of these tumors apparently develop from the bronchi. The form, size and extent are extremely variable and complications common. Histologically, all forms of cell types and tumor structure are seen. Metastases are frequent and usually extensive; metastases to the central nervous system often occur.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "ME," Medical Economics; "ab," abstract; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

For author index see page 2320.

A

ABDOMEN: See also Ascites
chronic discomfort in children, [Signorelli] 336—ab
hemorrhage (apoplexy; fatal intraperitoneal), [Moorehead & McLester] *373
hemorrhage (intra-abdominal) after normal delivery, [Küstner] 503—ab
hemorrhage (intraperitoneal), gallbladder perforation with, [Bartlett & Bartlett] *615
hemorrhage (massive), from ruptured corpus luteum cyst, [Jones] 2264—ab
operation; when can patient return to work, 1841
pain (acute upper), [Storey] 1524—ab
pain, etiology in diabetic acidosis, [Walker] 1850—ab
pain (recurrent), 1939
palpation, diagnostic, [Báron] 343—ab
Pregnancy: See Pregnancy, extra-uterine
roentgenograms of upper part, lower lung line in, [Korol] 654—ab
supports for compression in pulmonary tuberculosis, [Gordon] 417—ab
supports, Spencer, 2149
syndrome of right side, glycogenic functions of liver altered, [Lauro] 1235—ab
ABNORMALITIES: See also Cranium; Genito-Urinary Tract; Kidney; Knee; Legs; Ureters
congenital defects in siblings of malformed, [Murphy] *457; [Kleindienst] 502—ab
ABORTION, antecedent history of, in maternal mortality from septicemia, 1938
blood serum, vitamin E and antiproteolytic factor in, [Shute] 747—ab; 1768—ab
contagious, prevention and treatment of Br. abortus infections, 1754
criminal, persons sentenced for, 1101; 2165
criminal, poisoning by Chichester's Diamond Brand Pills, [Motley & McGehey] *1163
estrogenic substance rôle in, [Shute] 747—ab
habitual, 730
habitual miscarriage; advisability of uterine curettage, 317
induced by corn smut, [Dragisić] 1430—ab
induced by quinine sulfate? 2026
medical aspects, England, 2168
syphilis and, [Cole & others] *464
therapeutic, for tuberculosis, 2024
therapeutic, indications, 2168
treatment, progestin, [Falls & others] *271; 317
ABSCESS: See also Breast; Gonorrhea; Kidney; Lungs; Pons Varolii; Teeth; Tibia; etc.
Bartholin Gland: See Gonorrhea
pararenal (metastatic), [Steinert] 426—ab
perinephric (bilateral) in polycystic kidneys, [Twinem] *206
ABSOPURE Brand Orange Juice, 1009
ABSORPTION: See Carotene; Gastro-Intestinal Tract; Intestines; Skin
ACACIA Treatment: See Kidney disease
ACADEMIC Assistance Council: See Jews
ACADEMY: See also American Academy; etc.
Académie de chirurgie, 718
Accademia delle scienze mediche of Naples, meeting, 1750
Accademia di scienze medico-chirurgiche, 140
Accademia medica di Roma, 230
of Medicine: See also New York
of Medicine, France, (limit use of waters at health resorts), 56
of Medicine of Washington, 2011
ACANTHOSIS nigricans, liver injections for, [Strandell] 1434—ab
ACCIDENTS: See also Trauma; Workmen's Compensation Acts
Automobile: See Automobiles
caused by athletics, 936
fatal (Georgia), 712; (California), 1925
Industrial: See Industrial
instruction in technical hygiene, 935
Traffic: See Automobiles
ACETARSONE, chemical relationship to carbarsone and tryparsamide, [Epstein] *771
Treatment: See Syphilis, congenital
ACETOPHENETIDIN, relation to leukopenia, [Kracke] 1422—ab
ACETYLCHOLINE, autonomic system fibers which liberate, [Jackson] *359
ACETYLENE WELDING: See Oxyacetylene
ACHYLIA gastrica, intravenous chromoscopy with neutral red, [Allodi] 1692—ab
why is an achylic stomach with ulcer free from pain, 1028
ACID, Acetylsalicylic: See also Rheumatic Fever
acetylsalicylic, aminopyrine prescription incompatible, 2093
acetylsalicylic, poisoning, [Neale] 1609—ab
acetylsalicylic, prescription suggested, for safe analgesic, 1682
allylisopropylbarbituric, agranulocytosis after, [Olsen] 586—ab
Aminoacetic: See Dystrophy, muscular; Muscles, disorders
Ascorbic: See Acid, cevitamic
barbituric, poisoning, blood and spinal fluid in, 1215
barbituric, roentgen reaction elicited by, [Uhlmann] 1236—ab; (reply) [Trostler] 1588—C
boric, preservatives in cream, 481
boric, steeping hands in to prevent dermatitis from rubber gloves, [Bailly] 1224
boric, toxicity of, given subcutaneously by mistake, [Brown & others] 1221—C
Carbolic: See Phenol
Cevitamic: See also Psoriasis, treatment; Scurvy treatment; Vitamin C
cevitamic, claims permissible by Council, 1733
cevitamic, effect on blood coagulation, [Cotti] 1431—ab
Cevitamic, in Urine: See Urine, vitamin C
cevitamic, relation to adrenal cortex function, [Tislowitz] 167—ab
citric, in metabolism, 1737—E
citric producing from black mold, 1019
Diet: See Diet
fatty, desaturation, 1665—E
glutamic, as salt substitute, [Mainzer] 2205—ab
hardening fixing bath (photographic), sensitivity to, 1028
hydrochloric, effect on gastric healing, [Howes] 1045—ab
Iodoxyquinoline Sulfonic: See Amebiasis, treatment
oleic, dosage as cholagogue, 487
Oxalic in Urine: See Urine
oxalic, metabolism relation to liver, [Pennetti] 1611—ab
Picric: See Trinitrophenol
Tannic: See Burns, treatment; Tuberculosis, treatment
tartaric, reaction from hair washes, 1224
Therapy: See Tuberculosis
Trichloroacetic: See Moles; Verruca
ACID-BASE EQUILIBRIUM, disorders, gonadotropic hormones action in, [Bock] 582—ab
ACIDITY, Gastric: See Stomach
of tobacco smoking, 945
ACIDOPHILUS Milk: See Milk
Therapy: See Bacillus acidophilus
ACIDOSIS, coma after large doses of salicylates in rheumatic fever, 55
Diabetic: See Diabetes Mellitus
effect on electrocardiogram, [Barker] 324—ab
pre- and postoperative treatment, [Kirk] 586—ab
ACNE vulgaris, suction treatment, [Skutta] 1236—ab
vulgaris, Antuitrin-S treatment, [Lawrence] *983
ACOUSTICON, 1007
ACRODYNIA, pink disease (Swift's disease), 59
ACTINOMYCOSIS, pathogenesis, [Lord] 1042—ab
ACTINOPHYTOSIS: See Granuloma pyogenicum
ADAMS-STOKES Disease: See Heart block
ADDICTION: See Alcoholism; Morphine
ADDISON'S DISEASE, after adrenal denervation in diabetes, [Rogoff] *279; 294—E; [Hutton & others] 1753—C; (reply) [Rogoff] 1753—C
ADDISON'S DISEASE—Continued
muscle fatigability, 563
treatment, adrenal cortex extract, adrenotropic hormone, vitamin C and sodium chloride, [Raab] 664—ab
treatment, adrenal cortex extract effect on salt metabolism, [Kepler] 414—ab
treatment, adrenal cortex extract plus sodium chloride in crises, [Schultzer] 1138—ab
treatment, adrenal cortex extract (Wilson's), [Thompson] 415—ab
treatment, cevitamic acid, vs. adrenal cortex extract, [Tislowitz] 167—ab
treatment, sodium compounds, [Reifenstein] 2192—ab
ADENITIS: See Lymphatic System
ADENOCARCINOMA of pancreas, enzyme content, [Sugiura] 1419—ab
ADENOIDS, premedication and inhalation anesthesia for operation, [Gwathmey] 1230—ab
ADENOMA: See also Goiter
basophilic, 775—ab
subclinical, of pituitary, [Costello] 1849—ab
ADGENE, 1111—BI
ADHESIONS: See Joints; Pleura; Pneumothorax, artificial
ADHESIVE, elastic, use in skin grafting, [Bronaugh] 1856—ab
tape, toxicity of carbon tetrachloride for removing, 1755
ADIPOSITY: See Obesity
ADNEXA: See Uterus
ADOLESCENCE, acne vulgaris in, Antuitrin-S for, [Lawrence] *983
chlorosis; iron therapy, [Patek & Heath] *1463
delayed puberty in girl, 2093
development in girls, [Pryor] 959—ab
diets for boys in camps, 2254
effect of puberty on epilepsy, [Klessens] 1526—ab
psychoses in, 60; 295—E
sacro-iliac joint infection and spondylitis, [Scott] 1858—ab
ADRENALIN: See Epinephrine
ADRENALS: See also Addison's Disease
Cortex Extract: See Addison's Disease; Psoriasis
cortex, function relation to cevitamic acid, [Tislowitz] 167—ab
cortex reaction (Aron's) for cancer diagnosis, 1019
cortical hormone, relation to thyroxine and nitrogen metabolism, 541—E
defense of, 294—E
denervation and hyperadrenalism, 315
denervation in diabetes, Addison's disease after, [Rogoff] *279; 294—E; [Hutton & others] 1753—C; (reply) [Rogoff] 1753—C
denervation in juvenile diabetes, [de Takáts] 871—C
hemorrhage, Waterhouse-Friderichsen syndrome, [Aegerter] *1715
in amebiasis, [Waldorp] 1135—ab
insufficiency from atrophy, [Weller] 1231—ab
insufficiency in Simmonds' disease, [Rose] 1852—ab
irradiation in hypertension, 294—E; [Hutton] 1040—ab; [Hutton] 1753—C; (reply) [Rogoff] 1753—C
medulla insufficiency, symptoms, [Thannhauser] *908
rôle in calcium metabolism, [Schour] 1690—ab
rôle in intestinal resorption, 1749
stimulation, increases blood pressure, [Kuré] 2204—ab
tumor or chronic pancreatitis, 1412
ADRENERGIC Fibers: See Nervous System, Sympathetic
ADRENOTROPIC HORMONE treatment of adrenal insufficiency, [Raab] 664—ab
ADVERTISING: See also under Medicolegal Abstracts at end of letter M
A. M. A. resolution on, 1173; 1188; 1918; (from Section on Pharmacology and Therapeutics) 1922
Booklet for Ocean Clear Lobsters, 1009
"Canned Food Handbook" of American Can Company, 1565

ADVERTISING—Continued
Carnation Year Book of Menus and Recipes, 1009
Cooperative Medical Advertising Bureau, report, 1170
Copeland Food bill, 1175; 1179; [Woodward] ★1896; 1902—E
label and packages, Committee on Foods rules on, 1187
"Mellow Milk, Homogenized," 1166
"Mel-o-Tose No. 1," 1009
newspaper bars physicians and dentists from, New York, 2013
of high potency vitamin preparations to laity, Council statement on, 1732
of nostrums and appliances, bill restricting, England, 1402; 1829
Radio: See Radio
"Simplified Infant Feeding," 1474
AERONEUROSIS: See Psychoneurosis
AGE, Middle Age: See Middle Age
of parents vs. deficiencies of offspring, [Kleindienst] 502—ab
Old: See Old Age
AGRANULOCYTOSIS: See Angina
AIR: See also Humidity
compressed (pneumatic) tools, articular lesions from using, [Rostock] 1773—ab
Conditioned Fever Chamber (Hypertherm): See Fever, therapeutic
conditioning, A.M.A. resolution on committee to study, 1822; 1903
conditioning, Dr. John Gorrie father of, 1989—E
conditioning: relation to upper respiratory infections, [Hosmer] 496—ab
conditions in offices, 145
Embolism: See Embolism
filters: Kaiseraire Filter Ventilator, 1731
filters to relieve hay fever, 1940
hygiene, foundation to study, 474
Passages: See Respiratory Tract
Pressure: See also Barometric Pressure
pressure of 3 atmospheres, effects of oxygen at, [Behnke] 1038—ab
Raids: See Aviation
sickness, [Lenggenhager] 2203—ab
smoke nuisance, Tokyo, 2174
swallowing, belching, 1515
symposium on atmospheric environment by Harvard, 1670
Tight Drainage: See Empyema
AIRPLANE: See Aviation
ALASKA Strain: See Influenza virus
ALBERTY'S (Spleen and Iron Tablets) 143—BI; (German Herb Lax-Tonic) 143—BI; (Hemoglobin Tonic) 144—BI; (Organic Phosphate Pellets) 558—BI; (Food) 724—BI
ALBUMIN, egg white precipitin test in peptic ulcer, [Marks] 412—ab; 1848—ab
in Urine: See Albuminuria
ALBUMINURIA in digestive disorders, [Rohmer] 256—ab
stasis, hypoproteinemia and cardiac edema, [Ehrström] 1434—ab
ALBUMS, Health: See Health
ALCOHOL: See also Taverns
condemned, England, 2079
effect in catatonic syndromes, [Kantorovich] 572—ab
effect on digestion, [Blotner] ★1970
effect on insulin in diabetes, 730
effect on metabolism, 2171
Injection: See also Arteries, carotid; Dysmenorrhea, treatment; Nerves, phrenic; Pain, relief of; Pneumonia, treatment; Pruritus ani; Uterus cancer
injection (subarachnoid), cauda equina syndrome after, [Tureen & Gitt] ★1535
injection (subarachnoid), hypotonia and paralysis after, 1115
Intoxication: See Alcoholism
Isopropyl: See Isopropyl Alcohol
metabolism, 2019
rôle in calcium cyanamide poisoning from fertilizer, 237
vitamin E (α-tocopherol), 1496—E
Wood: See Methyl Alcohol
ALCOHOLISM, death rate from, 710—E
effect on digestion, [Blotner] ★1970
in traffic accident statistics, Germany, 868
nostrum, Curarina, 724—BI
nostrum, Health Anti-Liquor, 2088—BI
subintoxicated driver, 1580
treatment, carbon dioxide-oxygen inhalation, [Henderson] 64—C; [Newman & Card] ★595; [Selesnick] 1220—C
treatment of delirium tremens, [Steck] 963—ab
ALCOHOLIZATION: See Arteries, carotid; Arteries, spermatic
ALIENISTS: See Psychiatrists
ALIENS: See under Medicolegal Abstracts at end of letter M
ALIMENTARY Canal: See Gastro-Intestinal Tract
ALKALI Reserve: See Blood
Treatment: See Peptic Ulcer; Pyelitis
ALKALINE Diet: See Diet
ALKALOID: See Ergot
ALKALOSIS, effects on electrocardiogram, [Barker] 324—ab
ALLANTOIC stalk, abnormal shortness, [Politzer] 967—ab
ALLERGENS: See Anaphylaxis and Allergy
ALLERGY: See Anaphylaxis and Allergy; Edema, allergic; Food
ALLERTON Farm Brand Evaporated Milk, 617
ALLSWEET Brand Oleomargarine, 1009
ALLYLISOPROPYLACETYL carbamide, thrombocytopenic purpura after, [Boas] 1952—ab
ALMO Tonic, 558—BI
ALOE Short Wave Diatherm, 122
ALOES, poisoning by Chichester's Pills, [Motley & McGehey] ★1163
ALOPECIA during pregnancy, 944
trichotillomania, [Karrenberg] 582—ab
ALTHERM Sinus Pad, 921
ALTITUDE, High: See also Aviation
high, blood changes after exertion at, [Jezler] 2266—ab
high, physiology in, 1216
mountain climate as therapeutic factor, [Campbell] 2266—ab
ALUM, Chrome Alum Hardener: See Chromium
injections (intranasal) protects against poliomyelitis, [Peskind] 483—C
Precipitated Toxoid: See Tetanus
ALUMINUM Hydroxide Drip: See Peptic Ulcer, treatment
in food, from cooking vessels, 218—E
injected, fate, 1497—E
Oxide: See Diphtheria, immunization
do AMARAL, AFRANIO, 296—E; 1013; 1391
D'AMATO, LUIGI, 1405
AMBULANCE, first aid splints on, 628—E; 712
service, hospitals reporting, ★795
AMEBIASIS, adrenals in, [Waldorp] 1135—ab
complications, pleuropulmonary, [Ochsner] 1522—ab
diagnosis, [Chang] 2112—ab
diagnosis, bacteria-free antigen for complement fixation test, [Stone] 251—ab
diagnosis, three signs, [Castellani] 79—ab
experimental, effect of liver extracts, 1094—E
experimental infections, [Atchley] 1848—ab
intestinal obstruction due to, [Bassler] ★1965
no relationship to diabetes mellitus, 2094
treatment, iodoxyquinoline sulfonic acid, [O'Connor] 329—ab
treatment, oxygenation, [Golob] ★1725
unsolved problems in, 1662—E
AMENOCO Capsules, 1837—BI
AMENORRHEA, cyclic changes in vaginal mucosa? [Zondek & Friedmann] ★1051
in girls in work camps, Germany, 1747
in pulmonary tuberculosis, [Gál] 586—ab
AMERICAN: For Societies whose names begin with American see also list of societies at end of letter S
Academy of Arts and Sciences, 635
Academy of Pediatrics, 1578
Association for the Advancement of Science, 2015
Association for the Study and Control of Rheumatic Diseases, 1324
Association for the Study of Goiter, 2015
Bar Association, Mr. Will Shafroth's address at Kansas City Session, 1916
Board of Dermatology and Syphilology, 1498
Board of Internal Medicine formation, A.M.A. Section approves, 1921
Board of Obstetrics and Gynecology, examinations, 2078
Board of Orthopaedic Surgery examination, 547; 1578
Board of Pediatrics, certification, 223
Board of Radiology, certification to replace A. M. A. listing, 630—E
Board of Surgery, 1994
Board of Urology, examinations, 1401
Can Company, advertising leaflet, 1565
College of Physical Therapy, 239
College of Physicians, 635
Committee for the Control of Rheumatism, review of rheumatism, 1900—E
Committee on Maternal Welfare, 1323; 1995
Congress of Physical Therapy, 547; 2078
Council on Education, listing of films, 931
Farm Bureau Federation, A. M. A. Committee on Legislative Activities report, 1913
Federation for the Blind, 49
Federation of Labor not in favor of health insurance, 1915
Heart Association, meeting, 1323
Hospital of Paris, report, 1507
Indians: See Indians
Interne: See Journals
Lady Brand Apple Sauce, 1009
Legion (relation to A. M. A.) 1914; (resolution on control of veterans' medical service) 2075
MEDICAL DIRECTORY: See American Medical Association
Medical Golfing Association, 1203; 1286; 2010
Medical Skeet and Trap Shooters Association, 1203
Memorial Hospital in Rheims enlarged, 934
Philosophical Society, grant for study of anesthetics, 390
Proctologic Society, meeting, 1323
Public Health Association, meeting date changed, 1578
Radium Society, meeting, 1323
Universal Desk, 538
AMERICAN MEDICAL ASSOCIATION, address of Dr. Leon Asher, 1917
address of Mr. Shafroth of American Bar Association, 1916
American Legion and, 1914
AMERICAN MEDICAL DIRECTORY, report, 1170
Annual Conference of Secretaries, 1167
Annual Congress on Medical Education, Medical Licensure and Hospitals, 299; 1095; 1204; 1316; 1392; 1498; 1569
Archives of Internal Medicine, review of advancement of knowledge, 1169
Atlantic City place of 1937 Session, 1924
Atlantic City Session (1935), minutes adopted, 1814
Auditor's report, 1195
Board of Trustees (abstract of minutes), 860; (report) 1168; 1819; 1903; 1917; 1919; (portraits) 1620; (election of Trustee) 1924
British Medical Association invites representatives to its meeting, 861
Building: See A. M. A. headquarters
Bureau of Exhibits, report, 1186; 1918
Bureau of Health and Public Instruction, (Dr. Teschner appointed) 219; (report) 1184, 1817; 1918
Bureau of Investigation, (Dr. Clancy succeeds Dr. Cramp) 861; (report) 1185; 1918
Bureau of Legal Medicine and Legislation, (report) 1175; 1908; (cooperation with state and county societies) 1179; 1181; (memorandums on illegitimacy and Harrison Narcotic Act) 1819; 1910
Bureau of Medical Economics, (report) 1181, 1909; (questionnaire on rural medical care) 1914; 1916; 1919
Canadian Medical Association invitation to Toronto in 1939, 1819; 1907; 1918 (Dr. Routley's address) 1907
Chemical Laboratory, report, 1173
Committee on Awards, 1305; (report) 2009
Committee on Foods, (report) 1186, 1918; (criticism by Medical Society of New Jersey) 1173, 1188; (reorganization plan) 1173, 1188; 1806; 1918; (amend rules on use of seal) 1899; (vitamin D milk) [Jeans] ★2066; ★2150
Committee on Legislative Activities, (report) 1913, 1919; (trip to Washington) 1914
Committee on Medicolegal Blood Grouping Test, 1199
Committee on Publicity, 1910
Committee on Scientific Research, (report) 1191, 1918; (grants) 1192, 1391
Committee on Therapeutic Research, (report; grants) 1189; 1807; 1918
Committee to Study Contraceptive Practices and Related Problems, report, 1821; 1910; 1919
Committees (standing), nominations, 1924
constituent state associations, organization, 1167
Constitution and By-Laws, proposed amendments, 1913; 1920
Cooperative Committee on Vitamins, 1173; 1187
Cooperative Medical Advertising Bureau, report, 1170
Council on Medical Education and Hospitals (radiologic service) ★618; (certification of radiologists to be replaced by American Board) 630—E; (hospital service) ★783; 858—E; (hospitals approved) ★798; 874; (internships for foreign graduates) 1031; (cooperation, Judicial Council report) 1196; 1903 (report) [Wilbur] 1095—ab; 1198; 1819; 1904; 1921; (licensure statistics) ★1475; 1495—E; (blue-print committee) [McLester] 1816
Council on Pharmacy and Chemistry (Cyclopropane for Anesthesia) 292; (chondroitin) 293; (Ampoules of Pitressin) 382; (tribute to L. B. Mendel) 539; (Ephedritone Inhalant-Massey's) 617; (Tryparsamide Patent and Trademark) 781; (Phagoid Laboratories preparations) 962; (Ampoule Calcium Chloride 10% of Lakeside Laboratories) 1008; (Ergonovine) 1008; 1012—E; (Lactobacillus Acidophilus Milk—Towt) 1165; (report) 1171; 1917; (membership) 1173; (unfairly criticized by Medical Society of New Jersey) 1173; 1918 (reorganization plan) 1173; 1188; 1806; 1918; (standards for liver preparations) 1314—E; [Murphy] 2089—C; (Larostidin 'Roche') [Martin] ★1468, 1473; (Refined and Concentrated Antipneumococcic Serum Type VII-Lederle); 1564 (correction) 2150; (questions concerning vitamins) 1732; (annual meeting) 1806; (nomenclature of endocrine principles) 1808; (Androstine-Ciba) 2150
Council on Physical Therapy, (annual meeting) 1007; (reorganization plan) 1173, 1188; 1806; 1918; (report) 1174, 1918; (appreciation to consultants) 1899
Council on Scientific Assembly, (report) 1199; 1821
dues are due, 124—E
exhibit (at San Diego Exposition) 861; 1518; (at Dallas Exposition) 861
exhibitors, list, Kansas City Session, 1307-1312

AMERICAN MEDICAL ASSOCIATION—Continued
exhibits, Kansas City Session, 1296; 1307-1312; (awards) 1305; 2009
exhibits, (report) 1186
exhibits (special) on diabetes and on fractures, Kansas City Session, 1296
Fellowship, 1167; 1819; (Fellow shall present no more than one paper) 1905; (fitting recognition for distinguished service) 1913, 1921; (election) 1924
foreign guests, Kansas City, 296—E; 1013, 1391; 1313—E; 1810—E; 1905; 1906
General Scientific Meetings, Kansas City, 1284
golf tournament, 1203; 1286; 2010
Grants: See American Medical Association Committee on Scientific Research; American Medical Association Committee on Therapeutic Research
greetings to Dr. G. H. Simmons and Dr. Irvin Abell, 1924
headquarters building, alterations, report, 1170; (Chemical Laboratory) 1173; 1917
hospitals registered by, ★798; 874; 2026
House of Delegates (requests for special session) 860, 1187; (members) 1271, 1272; (minutes) 1814; (Speaker Van Etten's address) 1814; 1905; (members dying since June 1935) 1815; (Speaker, election) 1923; (Vice Speaker, election) 1924
Hygeia, (report) 1169; (in CCC camps) 1819; 1917
JOURNAL, (report) 1168; 1917; (mailing list), 1169 (resolution on Queries and Minor Notes) 1821; 1904; 2008
journals, special (elections to editorial boards) 861; (report) 1168; 1917
Judicial Council, (action on Ross-Loos case) 300; (report) 1196; 1819; 1903; 1906; 1917; (closer alliance with Council on Medical Education) 1196; 1903; (report on resolution on mechanical aids for physical defects) 1913; 1922
Kansas City Session, 129; 296—E; 711; 1013; 1203; 1271; 1313—E; 1319; 1391; 1498; 1569; 1665; 1810—E; 1814; 1903; 1993
Library, report, 1170
Local Committee on Arrangements, 1284
members who are serving sentence for felonies, 1903; 1913; 1922
membership, 1167
National Congress of Parents and Teachers extends greetings, 1819
NEW AND NONOFFICIAL REMEDIES, report, 1171
Officers, (reports) 1167; 1819; 1905; 1922; (list of) 1272; (election) 1923
policies, attitudes of groups of physicians toward, [Mason] 1817
President McLester, (address) 1815; 1907
President Mason (portrait) 1618; (address) ★1695; (serious illness) 1813—E; (message from) 1817; (interpretation of constitution on incapacity of) 1818; 1903; 1905; (message to) 1908; (installation) 1917; (death) 2252
President-Elect, (Chicago Medical Society endorses C. E. Humiston) 632; (election) 1923
President-Elect Upham, 1811—E; 1813—E; (address) 1923
Proceedings, Kansas City Session, 1814; 1903; 1993
program, Kansas City Session, 1287
Quarterly Cumulative Index Medicus (report) 1170; 1736—E; 1917
radio program (weekly) 1185; (broadcast from Kansas City) 1319; 1392; 1498; 1569; 1666
Reference Committee on Amendments of Constitution and By-Laws, report, 1920
Reference Committee on Credentials, report, 1814; 1903; 1919
Reference Committee on Executive Session, report, 1910; 1916
Reference Committee on Hygiene and Public Health, report, 1920
Reference Committee on Legislation and Public Relations, report, 1908; 1906; 1919
Reference Committee on Medical Education, report, 1904
Reference Committee on Miscellaneous Business, report, 1906; 1910
Reference Committee on Reports of Board of Trustees and Secretary, report, 1906; 1917
Reference Committee on Reports of Officers, report 1905; 1922
Reference Committee on Rules and Order of Business, report, 1821
Reference Committee on Sections and Section Work, report, 1904; 1919
Reference Committees, members, 1815
registration at Kansas City Session, 1282; 1823
resolution condemning unethical listing of physicians in directories, 1823; 1921
resolution on advertising of drugs, 1922
resolution on care of occupational disease, 1920
resolution on changing name of Section on Obstetrics, Gynecology and Abdominal Surgery, 1997
resolution on committee on asphyxia, 1822; 1910
resolution on committee to study air conditioning, 1822; 1903
AMERICAN MEDICAL ASSOCIATION—Continued
resolution on committee to study auto accidents, 1912; 1920
resolution on contraception, 1823
resolution on diagnostic medical service as part of hospital services, 1168
resolution on dividing medicine into technical and professional portions, 1822; 1904
resolution on division of radiology, 1822; 1904
resolution on entrance requirements to medical courses, 1823; 1904
resolution on establishing Section on Anesthesia, 1922
resolution on federal aid to hospitals, 1922
resolution on foreign graduates, 1912; 1921
resolution on granting approval to hospitals for general internships or residencies, 1823
resolution on group hospitalization plans including radiologic service, 2007
resolution on helium legislation, 1912; 1920
resolution on instruction in medical schools on organized medicine, 1188; 1918
resolution on mechanical aids for physical defects, 1913; 1922
resolution on National Congress of Obstetrics and Gynecology, 1996; 1997
resolution on one basic law governing industrial health, 1822
resolution on physicians on hospital staffs being local society members, 1198
resolution on practice of medicine by physicians and not by hospitals, 1822; 1906
resolution on preliminary military training of medical officers, 1093
resolution on pure food bill (Copeland) and advertising, 1173; 1188; 1918
resolution on Queries and Minor Notes, 1821; 1904; 2007
resolution on radio advertising, 1819
resolution on radio emergency calls to physicians, 1823; 1906
resolution on recognition of Fellows rendering distinguished service, 1912; 1921
resolution on scarlet fever patent, 1188
resolution on survey of public mental hospital services in U. S., 1922; 2002
resolution on teaching and consultation with optometrists, 1922; 1997
resolution on U. S. Department of Health, 1188
resolution on withdrawing approval from hospitals which grant special privileges, 1910
resolution that state society be notified when approval of hospital threatened, 1912; 1921
schools for clinical laboratory technicians, standards proposed, 1820; 1904
schools for physical therapy technicians, essentials proposed, 1819; 1904
Scientific Assembly, preliminary program, Kansas City Session, 1287
Scientific Exhibit, Kansas City Session, 47; 219; 1296; 2008
Secretary (report) 1167; 1819; 1919; (election) 1923
Section on Anesthesia, resolution on, 1922
Section on Dermatology and Syphilology, (program) 1292; (exhibit) 1301; (minutes) 2003
Section on Gastro-Enterology and Proctology, (program) 1294; (exhibit) 1303; (minutes) 2006
Section on Laryngology, Otology and Rhinology, (program) 1289; (exhibit) 1299; (minutes) 1998
Section on Miscellaneous Topics, 1295; (minutes) 2008
Section on Nervous and Mental Diseases (program) 1292; (exhibit) 1301; (breakfast) 1665; (minutes) 2002
Section on Obstetrics, Gynecology and Abdominal Surgery, (program) 1288; (exhibit) 1298; (minutes) 1995
Section on Ophthalmology, (program) 1289; (exhibit) 1299; (motion picture program) 1299; (minutes) 1997
Section on Orthopedic Surgery, (program) 1294; (exhibit) 1302; (minutes) 2005
Section on Pathology and Physiology, (program) 1291; (exhibit) 1300; (minutes) 2001
Section on Pediatrics, (program) 1290; (exhibit) 1299; (minutes) 1999
Section on Pharmacology and Therapeutics, (program) 1291; (exhibit) 1300; (minutes) 2000
Section on Practice of Medicine, (program) 1287; (exhibit) 1296; (approve American Board of Internal Medicine) 1921; (minutes) 1993
Section on Preventive and Industrial Medicine and Public Health, (program) 1293; (exhibit) 1302; (minutes) 2004
Section on Radiology, (program) 1295; (program) 1303; (minutes) 2009
Section on Surgery, General and Abdominal, (program) 1288; (exhibit) 1297; (minutes) 1994
Section on Urology, (program) 1293; (exhibit) 1302; (minutes) 2005
Sections and Section Work, report of Reference Committee on, 1904
AMERICAN MEDICAL ASSOCIATION—Continued
Sections (headquarters) 711; (meeting places) 1284; (programs) 1287; (exhibits) 1296; (representatives at exhibits) 1296; (portraits of chairmen and secretaries) 1622; 1624; (minutes) 1993
Senate Bill 4516 to provide subsidies for tuberculosis hospitals, 1821; 1920
Session on Tuberculosis, 1295; (minutes) 2008
Skeet and Trap Shoot, 1286
survey of graduate training of physicians, 1199
symposium on traffic accidents, 1304
Technical Exposition, 1306
Treasurer, (report) 1195; 1918; (election) 1923
U. S. Constitution Sesquicentennial Commission invites cooperation, 1823; 1920
USEFUL DRUGS, 1171
Vice President, election, 1923
Vice President Heyd, 1813—E; (address) 1923
Vice President Lynch, address, 1888
Woman's Auxiliary, 1286; 1579; 1810—E
AMFETIN: See Amniotic Fluid
AMIDO AZOTOLUENE, dermatitis from wrist watch straps caused by, 1738—E
AMIDOPYRINE: See Aminopyrine
AMINOACETIC ACID: See Acid (cross reference)
AMINOPHYLLINE preparations, Council report, 1807
AMINOPYRINE-acetylsalicylic acid prescription, incompatible, 2093
agranulocytosis after, [Olsen] 586—ab; [Hansen] 1774—ab; [Dameshek] 2177—C
dangers, 1213
effects on blood count, [Wilson] 420—ab
Ipral Amidopyrine Tablets 4.33 grains, 214
leukopenia and, [Kracke] 1422—ab
AMMON'S (Antiseptic Wash) 724—BI; (Gall Stone Remedy) 1111—BI: (Get Well, Eat Well, Stay Young) 1111—BI
AMMONIA Silver Salt Solutions: See Uterus cervix
Treatment: See Trichomonas
AMMONIATED Mercury: See Mercury
AMMONIUM Chloride Therapy: See Edema
AMNIOGRAPHY, placenta praevia diagnosed by, [Burke] 747—ab
AMNIOTIC FLUID concentrate as activator of peritoneal immunity, [Johnson] 1045—ab
effect on uterus contraction, [Fomina] 965—ab
intraperitoneal use of amfetin in surgery, [Gepfert] 1948—ab
AMNIOTIN: See Estrogenic Substances
AMPÈRE, ANDRÉ-MARIE, centenary, 1746
AMPUTATION: See also Appendix
how does it affect human beings? 477
painful stumps, sympathectomy in, [Adson] ★364
stump, cod liver oil treatment, [Iost] 586—ab
stump, pain in, in morphine addict, 1222
AMYL NITRITE test, technic, 484
AMYLENE Hydrate: See Anesthesia
AMYLOID bodies in epididymis, [Marsella] 1047—ab
disease, etiology, [Eklund] 955—ab; 1200—E
AMYLOIDOSIS: See also Kidney
tumor-like, congo red test, [Rosenblum & Kirshbaum] ★988
AMYLORRHEA in von Gierke's disease, [Naish] 2034—ab
AMYTAL, Tablets Amytal, ¼ Grain, 1661
ANAEROBES: See Bacillus
ANAHEMIN: See Anemia, Pernicious, treatment
ANALGESIA; ANALGESICS: See Anesthesia; Pain, relief of
ANAPHYLAXIS AND ALLERGY: See also Asthma; Dermatitis venenata; Hay Fever; etc.
allergens causing peptic ulcer, leukopenic index, [Gay] ★969
desensitization by trichophyton, 1591
diagnosis, history taking, [Rackemann] ★976
effects of vaccine injections on skin sensitivity, [Touart] 1042—ab
Gastro-Intestinal: See Food allergy
"hetero-allergy," rôle in tuberculous liquefaction, [Pagel] 2201—ab
hyperergic phenomena and histamine, [Gotsch] 1863—ab
immunity, tuberculin reaction and, 540—E
latent allergy, [Salén] 260—ab
mechanism of response, [Vaughan] 1765—ab
nonallergic soap, 644
rôle in arthritis, [Wootton] 740—ab
sensitivity to chicken and eggs, 2181
sensitivity to cold, 559
sensitivity to dental plates, [Rattner] ★2230
Sensitivity to Food: See Food allergy
sensitivity to ingested yeast, [Biederman] ★31
sensitivity to ophthalmic drugs, 404
sensitivity to pituitary extract, [Simon & Ryder] ★512
sensitivity to rubber in surgeons' gloves, 730; (reply) [Bailly] 1224
sensitivity to trichophytin, 943
sensitivity to tryparsamide, no record, 564
serum, fatal, 1326
serum shock, injecting B C G prevents, [Fraenkel] 1042—ab

ANAPHYLAXIS AND ALLERGY—Continued
serum sickness (local), [Seegal] 334—ab
serum sickness, remedy, 945
skin hypersensitivity in atopic dermatitis, [Sulzberger & Goodman] ★1000
skin tests, 1202—E
synovitis from walnuts, [Lewin & Taub] ★2144
teaching, status, [Kern] 1409—C
treatment, auto-urotherapy and urine proteose (Oriel's P substance), [Favelukes] 257—ab
unit for Veterans' Facilities, 223
vernal edema of lung, [Engel] 749—ab
ANASTOMOSIS: See Peptic Ulcer; Ureters
ANATOMISTS, Italian, commemoration, 721
ANATOMY: See Nervous System, Sympathetic
ANATOXIN: See Staphylococcus
ANCHOR Brand Oleomargarine, 1987
de ANDRADE, EDISON, typhus martyr, 310
ANDROGENS, use of female bitterling as test for, [Kleiner & others] ★1643
ANDROSTERONE benzoate treatment of impotence, [Steinach] 1862—ab
ANDROSTINE-Ciba, 2150
ANEMIA, achylous (simple), nerve symptoms in, [Abramson] 968—ab
blood circulation velocity, [Bertola] 1692—ab
chlorophyll and blood regeneration, 925—E
Chlorotic: See Chlorosis
etiology, daily exposure to sulfur, 65
experimental (iron metabolism), [Hahn] 653—ab; (iron therapy) [Whipple] 653—ab
experimental, rats fed human, cow's and goat's milk, [Beard] 74—ab
fatal, in 8 week old child, 1840
gastrogenic, [Petri] 344—ab
goat's milk, experimental, [Beard] 74—ab; [Schönenberg] 82—ab
hypochromic idiopathic, [Snyder] 2033—ab
hypochromic, in pregnancy, prevention, [Corrigan & Strauss] ★1088
hypoplastic, [Wiseman & others] ★612
in dinitrophenol poisoning, [Imerman & Imerman] ★1085
in stomach cancer, [Mogensen] 1240—ab
infectious (swamp fever) of horses, 1391—E
macrocytic, relation to hepatic disease, [Wintrobe] 1231—ab
multiple specific nutritional deficiency disease in the adult, [Haden] ★261
nature, in acute leukemia, [Jaffé] 76—ab
nervous sensations in legs in, 944
of pellagra, [Spies] 78—ab
of pregnancy, hydremia as factor, [Feldman] 1761—ab
of pregnancy, prevention, [Corrigan & Strauss] ★1088
reticulocytes increase after injecting "anemic" serum, [Hjort] 1864—ab
secondary, antianemic action of intestinal mucosa of hens, [Erös] 1614—ab
sickle cell, cause of cor pulmonale, [Yater] 1849—ab
treatment, ferrous tartrate, [Gram] 586—ab
treatment, transfusion, [Blumberger] 584—ab
treatment, vitamin B (yeast; Embo), 2092
ANEMIA, PERNICIOUS, blood in, carbonic anhydrase content, [Hodgson] 1857—ab
blood sedimentation speed, [Reichel] 258—ab
diagnosis, painful tongue, 2256
gastric juice, Castle's intrinsic factor in, [Greenspon] ★266; 295—E; [Goldhamer] 1687—ab; [Hanes & others] ★2058
gastric mucosa in, [Jones] 155—ab
gastric pepsin secretion in, [Mullins] 77—ab
in the adult, [Haden] ★261
myxedema and, [Holbøll] 426—ab
psychoses (symptomatic) in, [Preu] 572—ab
rôle of stomach in regulating blood formation, [Vlados] 1957—ab
spinal cord degeneration, rest and liver treatment, [Farquharson] 76—ab
splenomegalic polycythemia and, [Baráth] 752—ab
toxic factor in, [Wakerlin] 254—ab
treatment, antrum extract plus extrinsic factor, [Henning] 2203—ab
treatment, depepsinized stomach mucosa and depepsinized gastric juice, [Greenspon] ★266; 295—E; [Hanes & others] ★2058
treatment, diathermy, effect on liver cells, 1591
treatment, liver and stomach, standardization and labeling, 1172; 1807
treatment, liver (autolyzed concentrate), [Klumpp] ★1245; 1314—E
treatment, liver fraction (Dakin and West's anahemin), [Ungley] 1954—ab; [Wilkinson] 1954—ab
treatment, liver, method for preparing active hematopoietic agent, 1580
treatment, potency of preparations prescribed by Council, 1314—E; [Murphy] 2089—C
treatment, Solution Liver Extract-Valentine, 1661
ANESTHESIA: See also Medicolegal Abstracts at end of letter M
[Sykes] 1524—ab
A. M. A. Section on: See American Medical Association
accidents; explosions, 932
barbital compounds, ethobutylethylmalonylurea intravenously, [Desplas] 165—ab
*tri*brom-ethanol, alkali reserve after, 311
ANESTHESIA—Continued
carbon dioxide absorption technic in, [Waters] 739—ab
cyclopropane and tribrom-ethanol in amylene hydrate, [Wood] ★275
cyclopropane, Council report, 292
electrical, for dysphagia, [Grain] 2112—ab
electrocardiography during cyclopropane, ether, procaine, ethylene, nitrous oxide, vinyl ether, chloroform and tribrom-ethanol in amylene hydrate, [Kurtz & others] ★434; [Reid] 1513—C; [Raisbeck] 1513—C
encephalography with, [Aird] 1126—ab
ether, inhalation, advisability in whooping cough, 147; (reply) [Patterson] 1116
ether-oil rectal, in obstetrics, McCormick apparatus, where obtainable, 564
ethylene, policy of having x-ray units in surgical department, 647
ethylene, prevention of explosion in; Hodges "ensemble," 238
explosions in operating room, 134
explosions, precautions against, 932
for thyrocardiac patients, [Flaxman] 144—C; (reply) [Lahey Clinic] 144—C
In Obstetrics: See also Anesthesia, ether-oil in obstetrics, use by midwives, 1104
inhalation, for tonsil and adenoid operations, [Gwathmey] 1230—ab
leukocytosis after, [Boyd] 1127—ab
neglected in medical curriculum? survey, [Schwartz] ★1445
oil-soluble (procaine hydrochloride, butyl-para-aminobenzoate and benzyl alcohol) in rectal surgery, [Morgan] 255—ab
premedication and basal narcosis, 137
premedication for tonsil and adenoid surgery, [Gwathmey] 1230—ab
procaine infiltration of lumbar sympathetic for phlebitis, 56
research, American Philosophical Society grant for, 390
spinal, nervous complications after, [Brock & others] ★441; [McDonald & others] 1220—C; [Schwartz] 1513—C
spinal, streptococcic meningitis after, [Marick] ★2238
ANEURYSM, arteriovenous, reversible heart enlargement in, [Walker] ★1795
carotid cavernous arteriovenous, treatment, [Dandy] 76—ab
popliteal, [Wells & others] ★1264
traumatic, of wrist, 318
treatment, surgical, [Romanis] 882—ab
ANGINA, agranulocytic after allylisopropyl-barbituric acid, [Olsen] 586—ab
agranulocytic, after aminopyrine, [Olsen] 586—ab; [Hansen] 1774—ab; [Dameshek] 2177—C
agranulocytic, after benzene ring drugs, [Kracke] 1422—ab
agranulocytic, bone marrow changes in, [Stevenson] 333—ab; [Darling] 1037—ab
agranulocytic, dinitrophenol poisoning, granulopenia, [Imerman & Imerman] ★1085
agranulocytic, granulocytopenia, liver therapy promising, advises against x-ray, [von Bonsdorff] 2268—ab
agranulocytic, granulocytopenia, malignant neutropenia or agranulocytosis, 1495—E; [Dameshek] 2177—C
ANGINA PECTORIS, cardiodiaphragmatic, [Porter] ★992
causes of coronary thrombosis, [Phipps] ★761; [Willius] ★1893
diagnosis, prognosis, treatment, [Perry] 1133—ab
heart block relation to, [Salcedo-Salgar] 569—ab
in locomotive engineer, 2094
intermittent claudication relation to, [Kisch] 1613—ab
treatment; sodium chloride intravenously advisable? 728
treatment, sympathectomy, 2183
treatment, thyroidectomy, [Bisgard] ★1639
treatment, trichlorethylene, of Krantz, 485
ANGIOMA: See also Glomangioma; Hemangioma
treatment, carbon dioxide snow, diathermy or ultraviolet rays, 561
treatment of nevus vasculosus, 1680
ANGIONEUROSIS, treatment, posterior pituitary extract, [Klein] 424—ab
ANHYDRASE, Carbonic: See Blood
ANHYDROSIS: See Sweating
ANILINE, Paranitro-anilinediazonium Chloride: See Pregnancy diagnosis
Therapy: See Leprosy
toxicity in textile industry, 317
ANIMAL EXPERIMENTATION bills, U.S., 1180
report on, Netherlands, 228
ANIMALS: See also Chicken; Dogs; Horses; Lemmings; Mice; Rats; etc.
Charcoal: See Erysipelas, treatment
slaughter according to Jewish rite (schächten banned), 1747
slaughtered, cancer in, 935
veterinary help for, in Abyssinia, 1214
ANKLE, edema (chronic) 1030
joint injury in football players, [Lerch] 583—ab
symmetrical fat on, 239
ANKYLOSIS: See Arthritis; Temporomandibular Joint
ANOMALIES: See Abnormalities; Kidney; Testis, undescended; Ureters
ANOMALOSCOPE: See Color Blindness, 148
ANOREXIA: See Appetite
ANTHEIL, GEORGE, article on ductless glands in *Esquire*, [Berman] 1754—C
ANTHRANOL: See Ringworm
ANTHRAX, Belgian law providing workmen's compensation for, 1676
ANTHROPOMETRY: See Infants, New-Born, size of; Tuberculosis in children
ANTIBODY, Heterophile: See Pneumonia, treatment
ANTIDYSENTERY Serum: See Dysentery
ANTIEMETICS: See Vomiting
ANTIGEN: See Amebiasis, diagnosis; Chancroid; Lymphogranuloma inguinale
Bacteria-free: See Amebiasis, diagnosis
ANTIMONY Potassium Tartrate: See Lymphogranuloma inguinale
ANTIOXIDANTS: See Liver oils
ANTIPASTO, imported, food poisoning from, 543
ANTIPROTEOLYTIC Factor in Serum: See Blood
ANTISERUM: See Dysentery; Tularemia
ANTISTREPTOLYSIN: See Streptococcus, hemolytic
ANTITHYROID Protective Substance: See Thyroid
ANTITOXIN: See also Botulism; Tetanus
action of vitamin C, [von Gagyi] 1237—ab
ANTRUM Extract: See Anemia, Pernicious
of Highmore: See Maxillary Sinus
ANTUITRIN-S: See Gonadotropic Principles
ANUS fissure, quinine-urea injection for, 1331
Fistula: See Fistula
painful conditions, oil-soluble anesthetics for, [Morgan] 255—ab
Pruritus: See Pruritus
AORTA disorders, diagnosis, [Ude] 2204—ab
lesions in atherosclerosis, [Leary] 2194—ab
stenosis: etiology; morbid anatomy, [Gibbs] 578—ab
thoracic, arteriography, [Nuvoli] 1525—ab
AORTIC VALVE insufficiency in exophthalmic goiter, [Parade] 82—ab
APIOL: See Ergoapiol
APOPLEXY: See Abdomen hemorrhage; Brain hemorrhage
APPARATUS: See also Anesthesia; Diathermy; Instruments; etc.
A. M. A. resolution on mechanical aids for physical defects, 1913; 1922
Air-conditioned Fever Chamber (Hypertherm): See Fever, therapeutic
bill to restrict advertising of appliances, England, 1402; 1829
Brace: See Knee joint; Spine
Copeland bill, 1175; 1179; [Woodward] ★1896; 1902—E
dark room (umbrella with curtains), [Olsho] ★115
for administering parenteral fluid, [Walter] ★1982
for culture of human bone marrow, [Osgood & Muscovitz] ★1888
for intestinal intubation, [Abbott & Miller] ★17
for measuring bile pressure, [Kipp] ★2225; [McGowan & others] ★2228
for preparing tribrom-ethanol in amylene hydrate, [Wood] ★276
gastroscope, [Strauss] ★285
motorized oscillating bed, [Sanders] ★916
suspension, with overhead block and tackle and Sayres head sling, [Hanflig] ★524
X-Ray: See Roentgen Rays
APPENDECTOMY, mortality according to diagnosis, [Reid & others] ★668
APPENDICITIS: See also under Medicolegal Abstracts at end of letter M
acute, [Greiner] 81—ab
acute, mortality, factors, [Pattison] 1763—ab
acute, mortality, reducing, 2160—E
acute, paralytic ileus in, treatment, 307
statistical study, [Reid & others] ★665
APPENDIX, amputation (spontaneous), rare, [Beluth] 661—ab
Meckel's diverticulum arising from base, [Hadley & Cogswell] ★537
mucocele; myxoglobulosis, [Meyer] 1615—ab
APPETITE, anorexia in child, 1680
anorexia nervosa, [Berkman] ★2044
effect of heated house dust odor on, [Winslow] 952—ab
loss of, and vitamin B, 1710—ab
APPLES, lead poisoning from sprayed, 1589
sauce, brands accepted, 1009; 1474
APRICOTS, Heinz Brand, 1474
AQUINO, PEDRO B., death, 1510
ARCHIV für Schiffs- und Tropenhygiene: See Journals
ARGYRIA, becoming manifest in pregnancy, [Raaf & Gray] ★916
danger after lavage of kidney pelvis and bladder with silver nitrate? 1413
occupational, [Harker] 255—ab
ARIZ-Sweet Brand Grapefruit Juice, 1474
ARKO (Eczema Salve) 1111—BI; (Healing Salve) 1837—BI
ARM: See also Elbow; Fingers; Forearm; Hand; Wrist
pain due to cervical arthritis, [Hanflig] ★523
Ringworm: See Ringworm

ARMY: See also Military; Soldiers; Veterans; War
French, tuberculin reactions in, 1931
German, physical examinations for service, 2171
Italian, (sanitary condition of colonial troops) 140; (transfusion in) 309
U. S.: See also Spanish-American War
U. S., Army Medical Library, 53; 1736—E
U. S., (health, annual report) 133; (course for reserve medical and dental officers) 865; (medical R. O. T. C.) 1093—E; 1176; 1180
ARNETH Count: See Leukocytes
ARON'S Reaction: See Cancer diagnosis
ARRHYTHMIA: See also Auricular Fibrillation; Auricular Flutter; Ventricular Fibrillation
extrasystoles, genesis; therapy, [Pal] 1137—ab
incidence under anesthesia, [Kurtz & others] ★434
ARSENIC, poisoning from paint, 238
polyneuritis, striae of nail in, [Mees] 968—ab
skin reaction with trivalent and pentavalent arsenicals, 726
treatment, number of leukocytes in, [Halter] 966—ab
ARSENITE, Sodium: See Leishmaniasis
ARSINE intoxication in zinc oxide factories, Netherlands, 2019
ARSPHENAMINE: See also Neoarsphenamine
dermatitis, experimental, [Cormia] 1601—ab
hematologic reactions after, [Rich] 1765—ab
relation to leukopenia, [Kracke] 1422—ab
Treatment: See Syphilis
ART, Haden Etching Club Exhibit, New York, 131
medical, exhibit, Delaware, 2074
New York Physicians Art Club, 714; 1504
of Medicine: See Medicine
Physicians' Art Society, exhibit, Boston, 1015
ARTERIECTOMY in arterial obliterations, [Leriche] 883—ab
ARTERIES: See also Aneurysm; Arteriosclerosis; Arteritis; Blood Vessels; Veins; etc.
Carotid: See also Aneurysm
carotid, alcoholization for occipital neuralgia, [Kessel] 748—ab
carotid, injecting thorotrast into, for visualizing cerebral vessels, [Loman] 1599—ab
Coronary: See also Arteriosclerosis; Thrombosis, coronary
coronary, acute fatal insufficiency, [Levy & Bruenn] ★1080
coronary alternans (electrical), [Hamburger & others] ★902
coronary, circulation, theobromine-phenobarbital preparation effect on, 1593
coronary disease and tobacco, [Trasoff] 1689—ab
coronary disease, relation to heart block, [Salcedo-Salgar] 569—ab
coronary disease, saline intravenously for, [Feinberg] 1687—ab
coronary disease, theophylline for, [Smith] 332—ab
Coronary Occlusion: See Thrombosis, coronary
Embolism: See Embolism
Excision: See Arteriectomy
hepatic, liver tissue after ligating, [Loeffler] 2194—ab
homologous, and localization of disease, [Wiesner] 1239—ab
injections into, in diseases of limbs, [Luccarelli] 257—ab
Mesenteric: See Embolism
Occlusion: See Embolism; Thrombosis
Popliteal: See Aneurysm
Pressure in: See Blood Pressure
Pulmonary: See also Ayerza's Disease
pulmonary, x-ray study, [Schwedel] 1947—ab
Roentgen Study: See also Aorta; Arteries, pulmonary
roentgen study in gangrene of feet from ergotamine, [Yater & Cahill] ★1625
rupture (spontaneous) of gastric and superior mesenteric, [Moorehead & McLester] ★373
spermatic, alcoholization for impotence, [Popow] 748—ab
Temporal: See Arteritis; Periarteritis nodosa
ARTERIOGRAPHY: See Aorta; Arteries, roentgen study
ARTERIOSCLEROSIS, abdominal apoplexy, [Moorehead & McLester] ★373
atherosclerosis: aortic lesions, [Leary] 2194—ab
circulatory difficulties in, 2180
coronary, developing new blood supply to heart by operation, [Beck] 75—ab
coronary, saline intravenously for, [Feinberg] 1687—ab
glossodynia in, [Gilpin] ★1722
in diabetes, [Beck] 572—ab; [Root] 1039—ab; [Collens] 1849—ab
in thyrotoxicosis, [Maher & Sittler] ★1546
obliterans, arteriectomy in, [Leriche] 883—ab
obliterans, use of Pavaex, [Conway] ★1154
treatment, passive vascular exercise (Pavaex), [Wilson & Roome] ★1885; 1986
ARTERITIS: See also Endarteritis; Periarteritis
temporal, new syndrome, [Horton & others] 246—ab
ARTHRITIS: See also Rheumatism
allergy rôle in, [Wootton] 740—ab
ARTHRITIS—Continued
American Association for the Study and Control of Rheumatic Diseases, 1324
atrophic (chronic), effect of carbohydrate diet and insulin, [Bowen] 1233—ab
atrophic, leukocyte concentrate treatment, [Hartung] 1233—ab
atrophic, protein studies in, [Davis] 1233—ab
blood in, [Hartung & others] ★1448
blood in, guttadiaphot method, [Gulbin] 343—ab
cervical, pain in shoulder girdle, arm and precordium from, [Hanflig] ★523
chronic, life course in, [Nissen] 420—ab
chronic, massive doses of vitamin D (Viosterol), [Vrtiak & Lang] ★1162; (correction) 1828
chronic, of tuberculous origin, [Copeman] 1133—ab
chronic, operations on sympathetic in, [Adson] ★362
chronic, parathyroids in relation to, [Wootton] 1854—ab
chronic, relation to rheumatic fever, [Dawson] 1764—ab
chronic, subcutaneous nodules in, [Katz] 1432—ab
gonorrheal, differential diagnosis, 1840
Gouty: See Gout
Hypertrophic: See Osteo-arthritis
polyarthritis (acute), rare exanthem in, [Van Der Sande] 504—ab
polyarthritis (ankylosing), parathyroidectomy in, [Fedorov] 2268—ab
present status, second review, 1900—E
Rheumatoid: See Arthritis, chronic
Still's disease, [Hajkis] 1240—ab
Streptococcus hemolyticus fibrinolysis in, [Stuart-Harris] 1133—ab
Treatment: See also Arthritis, chronic
treatment, bee venom, (Beck method), 1588
treatment, chaulmoogra oil, 1411
treatment, histamine injection, [Eastwood] 961—ab
treatment, lumbar ganglionectomy and trunk resection, [Bothe] 2103—ab
treatment, sulfur, [Krestin] 882—ab; 943
treatment, typhoid vaccine, 2093
treatment, vaccines, 1115
tuberculous, problem of surgery, 1215
tuberculous, treatment, Gauvain's, 1929
ARTHROSCOPY: See Knee
ASBESTOSIS: See Pneumoconiosis
ASCHHEIM-ZONDEK Test: See Pregnancy, diagnosis; Uterus, hydatidiform mole
ASCHOFF, LUDWIG, 70 years old, 935
ASCITES: See also Edema
Talma's operation, [Henningsen] 1612—ab
ASCORBIC Acid: See Acid, cevitamic
ASHER, LEON, foreign guest at Kansas City Session, 1917
ASPARAGUS, Cellu Brand Tips, 1473
ASPERMIA, 728
ASPHYXIA: See also Cyanosis
A. M. A. resolution on committee on, 1822; 1910
intra-uterine, treatment, [Hecht] 663—ab
neonatorum, resuscitation, [McGrath & Kuder] ★885
ASPIRIN: See Acid, acetylsalicylic
ASSAULT AND BATTERY: See under Medicolegal Abstracts at end of letter M
ASSOCIATED Hospital Service of New York, 1577
ASSOCIATION: See also American; International; list of Societies at the end of letter S
for International Protection of Humanity, 1828
for Protection Against Aerial Warfare, 396
for Research in Ophthalmology, 1505
of American Medical Colleges, [Rypins] 1395—ab
of Italian Clergy, tuberculosis sanatorium, 230
of Military Surgeons of United States, 1498
ASTHENIA, neurocirculatory, in thyrotoxicosis, [Maher & Sittler] ★1555
ASTHMA, bakers', 1937
case history taking in, [Rackemann] ★976
chest deformities induced in, 134
epinephrine and opium contraindicated, 67
etiology, chlorine, in paper mill, 2024
etiology, linseed oil treatment of eczema, [Taub & Zakon] 642—C
hair dressing ("setting") for child, 1839
hypochlorhydria in, [Gillespie] 80—ab
intractable, leukopenic index in, [Zeller] 956—ab
psychogenic factor in, 1011—E
Research Council report, 134
treatment, autovaccine, Arneth count in, [Napier] 2200—ab
treatment, epinephrine, effects of long continued use, 148
treatment, epinephrine, tetany after, [Ellsworth & Sherman] ★284
treatment, ethylhydrocupreine, [Service] 741—ab
treatment, exercises in, 134
treatment, fever (Kettering hypertherm), [Metz] ★1658
treatment, helium, [Barach] 572—ab
ASTRINGENT preparation, bacteriostatic, 1682
solutions, continuous use of in nose, 148
ATABRINE Treatment: See Malaria
ATHEROSCLEROSIS: See Arteriosclerosis
ATHLETICS: See also Exercise; Physical Education
Accidents: See also Football
accidents caused by, 936
ATLANTIC City Session: See American Medical Association
County Medical Society, public health education, [Carrington & Kilduffe] ★2098
ATMOSPHERE: See Air
ATMOSPHERIC Pressure: See Barometric Pressure
ATOPIC Dermatitis: See Dermatitis
ATROPHY: See also Adrenals; Arthritis, atrophic; Bones; Dermatitis, atrophic; Diaphragm; Fat; Nerves, optic
muscular, 941
ATROPINE, effect on emptying time of stomach, [Herrin] 1762—ab
Treatment: See Stomach disorders
AUDIOMETERS, A. M. A. resolution on, 1913; 1922
AUDIPHONE, Western Electric, 1386
AUDITORY Nerve: See Nerves
AURICLE: See Heart
AURICULAR FIBRILLATION, in thyrotoxicosis, [Maher & Sittler] ★1556
paroxysmal, after thyroidectomy, [Boas] ★2238
treatment, strophanthin, [Rykert] 1602—ab
uncomplicated, [Orgain] 1763—ab
with apoplexy, [Perkins] 2262—ab
AURICULAR FLUTTER, audible auricular sound in, [Ludwig] 1612—ab
uncomplicated, [Orgain] 1763—ab
AUTOHEMOTHERAPY: See Hemotherapy
AUTOMOBILES accidents, A. M. A. resolution on committee to study, 1912; 1920
accidents, A. M. A. symposium on, 1304
accidents, course in control of car to reduce, Harvard, 712
accidents, first aid treatment of fractures, 628—E; (splints on ambulances) 712
accidents, 5 year program to reduce, 132
accidents (road), England, 550; 2168
accidents, study laws relating to, Conn., 1739
accidents (traffic) and alcoholism, Germany, 868
accidents (traffic), Netherlands, 228
accidents, traffic safety program of National Congress of Parents and Teachers, 1743
accidents, U. S., 223; 1828; 1928
drivers, sense of direction in, 1329
drivers, subintoxicated, 1580
garage workers, carbon monoxide headache in, 1332
Gas: See Gasoline
how cars go out of control, 386—E
victims, list of, Miss., 2075
AUTONOMIC Nervous System: See Nervous System, Sympathetic
AUTOPSIES, lawful authorization, [Woodward] ★33
AUTOTRANSFUSION: See Blood Transfusion
AUTO-UROTHERAPY: See Anaphylaxis and Allergy
AVIATION, air attacks, (protect hospitals from, Italy) 140; (Association for Protection against) 396; (precautions, England) 933, 1506; (France) 1746; (30 million gas masks, England) 1830
air sickness, [Lenggenhager] 2203—ab
antimosquito measures for tropical line, 1019
medicine, course in, U. S., 932
medicine, reunion of physicians, 1216
physiologist wanted for U. S. Air Corps laboratory, Dayton, 92
pilots, functional psychoneuroses in, [Armstrong] ★1347
pilots, functions from psychophysiologic angle, 1216
AVITAMINOSIS: See Vitamin
AVONDALE Farms Pasteurized Homogenized Milk, 1809
AWARDS: See Prizes
AYERZA'S DISEASE, bronchial factor in, [Castex] 1692—ab
AZOCHLORAMID: See Wounds, infected
AZOOSPERMIA: See Spermatozoa
AZOTEMIA: See Blood urea

B

BACILLEMIA: See Tubercle Bacillus
BACILLUS: See also Bacteria; Bacterium; Diphtheria; Plague; Tubercle Bacillus; Typhoid
acidophilus, implantation from whey cultures, [Brown] 162—ab
acidophilus, Lactobacillus Acidophilus Milk (Towt), 1165
alcaligenes, undescribed, [Hazen] 2105—ab
anaerobic, and urinary calculi, [Runeberg] 1434—ab
anaerobic, septicemia due to, 2242—E
coli (hemolytic) in chronic ulcerative colitis, [Nicholls] 1338—ab
coli in sewage, Eijkman vs. other tests for, [Hajna] 252—ab
coli, Phagoid-Bacillus Colon, 922
coli pyelitis, alkalis for, [Osman] 2200—ab
coli, vaccine therapy, [Mateer] 570—ab
funduliformis, septicopyemias due to, [Lemierre] 426—ab; 1748
histolyticus filtrate (Ensol) injections, effect on epithelioma, [Pommerenke] ★1654
Pertussis: See Whooping Cough

BACILLUS—Continued
Pfeiffer: See Influenza
welchii infection after hypodermoclysis, [Tenopyr & Shafiroff] ★779
BACK, Pain in: See Backache
BACKACHE, chronic, heat therapy, [Gill] ★42
spondylolisthesis with low back pain, 1413
BACTEREMIA: See Septicemia; Streptococcus
BACTERIA: See also Bacillus; Bacterium
in Blood Stream: See Blood; Septicemia
mephitibic, candle jar method for isolating, [Nye & Lamb] ★1075
BACTERICIDES: See also Disinfectants
power of vitamin C, [von Gagyi] 1237—ab
BACTERIDS, pustular, of hands and feet, [Andrews] 418—ab
BACTERIOLOGISTS, meningitis martyr, 129
Society of American Bacteriologists, 132
Society of Illinois Bacteriologists, 1925
BACTERIOLOGY, course in, at Massachusetts Institute of Technology, 1015
International Congress on Microbiology, 1325
Utrecht Institute of, 228
BACTERIOPHAGE, Phagoid Laboratories, Inc., preparations, 922
Treatment: See Cholera; Colds
BACTERIOSTATIC Astringent Preparation: See Astringent
BACTERIUM, Brucella abortus Infection: See Abortion, contagious; Undulant Fever
necrophorum in chronic ulcerative colitis, [Dack & others] ★7
pyocyaneum (mucoid form) in pyelonephritis, [Dahr] 257—ab
Tularense: See Tularemia
BAKERS, occupational hazards in, 1937
BAKING SODA: See Sodium bicarbonate
BALDNESS: See Alopecia
BALLANCE, CHARLES, death, 1325; 1506
BALLOONS, Rubber: See Intestines, intubation
BANANA, dried ripe, "Mel-O-Tose" advertising leaflet, 1009
BANDAGES: See Dressings
BÁRÁNY, ROBERT, death, 1828; 2173
BARBITAL: See also Acid, barbituric; Amytal; Phenobarbital
Anesthesia: See Anesthesia
poisoning (suicidal); recovery, [Chang & Tainter] ★1386
BAROMETRIC PRESSURE, effect on basophilic aggregation counts, [Gowen] 2105—ab
reduced, effect on hypophysectomized animals, [Meyer] 325—ab
BARTHOLIN GLAND Abscess (gonorrheal): See Gonorrhea
BASIC SCIENCE Acts; Boards: See Medical Practice Acts; Medicolegal Abstracts at end of letter M
BASOPHIL Adenoma: See Pituitary
BASOPHILIA: See Erythrocytes
BASOPHILISM: See Pituitary
BASS-JOHNS Chamber: See Blood counting
BATHING: See under Baths; Swimming
BATHS, Acid Hardening Fixing: See Acid
effect on venous pressure, [Krüger] 752—ab
hot, hyperpyrexia by, for syphilis, [Dennie] 657—ab
mud, for sciatica, 235
physician sued for preventing patient with scabies from entering, 1833
pruritus, 559
puerperal infections after, before delivery, [Koller] 963—ab
taking, during menstruation, 452—ab
BATTERIES, flashlight, industrial hazards, 1591
BAUER, JULIUS, Nazi officials object to his heredity theory, 937
BCG: See Tuberculosis, immunization; Tuberculosis, Vaccine
BEANS, Cellu Brand, 923; 1474
BEARD, deficiency of, 874
BECK'S Bee Venom Treatment: See Arthritis
BÉCLÈRE, ANTOINE, 80th birthday, 1508
BED: See also Bicycle; Mattresses
motorized oscillating, [Sanders] ★916
BEDRIDDEN, spectacles for, 71; (adv. page 26 Jan 11, '36 issue)
BEE Venom: See Arthritis, treatment
BEEF, Hormel Brand Corned Beef Hash, 1474
BEER Gardens: See Taverns
BEETLE, capricorn, tetanus transmitted by bite of, [Schmorell] 169—ab
BEETS, Cellu Brand, 1565
BEHAVIOR, mental health problem, [Casparis] ★2207
BELCHING, 1515
BELL, WILLIAM H., retires, 865
BELL'S Palsy: See Paralysis, facial
BELLADONNA: See Stomach disorders
BENEDICT'S solution (formula given), 942
BENZEDRINE Sulfate: See Sleep disorders
BENZOATE, Sodium: See Liver function test; Lungs, abscess; Lungs, gangrene
BENZYL Alcohol: See Anesthesia, oil-soluble
BEQUESTS: See Hospitals
BERCOVITZ Test: See Pregnancy diagnosis
BERIBERI, cardiac enlargement in, [Walker] ★1795
BERLIN Medical Society, discuss diabetes mellitus, 1508
Pediatric Society, 309
BERMAN, LOUIS, disclaims article on ductless glands in *Esquire*, 1754—C
BETTS Ready to Read Tests: See Vision, testing
BEVERAGES, Alcoholic: See Alcohol
Krim-Ko Chocolate Flavored Drink, 215
Krim-Ko's Five-O Chocolate Flavored Sweetened Diluted Skim Milk, 123
BIBLIOGRAPHY, John Shaw Billings and Army Medical Library, 1736—E
BICARBONATE of Soda: See Sodium bicarbonate
BICYCLE, "bed," to prevent thrombosis and phlebitis, [Dalsgaard] 1138—ab
BILE cholesterol in pregnancy, [Potter] ★1070
effect on vitamin C resorption, [Klodt] 2036—ab
pressure, variations, [Kipp] ★2223; [McGowan & others] ★2227; 2242—E
rôle in vitamin A utilization, 709—E
BILE DUCTS, atresia (congenital) and vitamin A deficiency, [Altschule] 573—ab
choledochotomies, [Bernhard] 662—ab
obstruction (physiologic), [Best] 337—ab
pressure in, relation to pain after cholecystectomy, [McGowan & others] ★2227; 2242—E
roentgen study during operation, modified technic, [Robins] 1953—ab
BILIARY TRACT: See also Bile Ducts; Gallbladder; Liver
bile pressure in, [Kipp] ★2223; 2242—E
calculi, microchemical study, [Ray] 160—ab
disease, bilirubin in blood serum, [Bengolea] 964—ab
disease, glycosuria with, [Lande] 332—ab
BILIRUBIN concentrations in gallbladder, [Elton] 952—ab
in Blood: See Blood
BILIRUBINEMIA: See Blood
BILLINGS, JOHN SHAW, and Army Medical Library, 1736—E
BING, FRANKLIN C., secretary of Committee on Foods, 1187
BIOPSY, directed, 718
BIRTH, Date of: See Labor
in Hospitals: See Hospitals, maternity
Injury: See Infants, New-Born
order of, and age of parents vs. deficiency in child, [Kleindienst] 502—ab
BIRTH CONTROL, A. M. A. committee on, report, 1821; 1910; 1919
A. M. A. resolutions on, 1823
council on contraception, China, 1107
in Germany, 1582
Indian women and, 636
legislation, U. S., 1177; 1180
"Safe Period": See Menstruation
BISMUTH, preparations, status, Council report, 1807
Salicylate: See also Frambesia
Salicylate in Oil-U. S. S. P. Co., 1661
Sodium Bismuth Iodide: See Iodobismitol
Sodium Tartrate-Searle, Ampoules, 2150
Treatment: See Syphilis, prevention; Syphilis treatment
BITE: See Beetle; Spider
BITING Nails: See Nails
BITTERLING TEST for male hormone, [Kleiner & others] ★1643
BLACK Mold: See Mold
Widow: See Spider
BLACKWATER FEVER, [Fernán-Núnez] 1850—ab
BLADDER, blood clots in, removal, 1940
cord, operation on sympathetic for, [Adson] ★366
Fistula: See Fistula
inflammation (severe), uretero-intestinal implantation for [Wright] ★1804
lavage with silver nitrate, argyria after? 1413
photographic cystoscopes, 1515
rupture with prostatic hypertrophy, [Scholl] ★701
Sphincter: See Sphincter Muscles, vesical
surgery for urinary fistulas and incontinence, [Martius] 1049—ab
surgery, suprapubic incisions, closing, [Davis] 743—ab
BLAIR-BELL, WILLIAM, death, 475
BLASTOMYCOSIS, complement fixation test in, [Martin] 334—ab
BLEACH Gas: See Chlorine
BLIND, American Federation for, building, 49
care of war blinded, England, 1745
BLINDNESS, causes and definition, 58
Color: See Color Blindness
BLINKING, stammering and left-handedness, 1681
BLOCH-HEIM Suggestion Treatment: See Verruca
BLONDES and eugenics, 67
skin infections in, 1756
BLOOD: See also Hemorrhage; Hemotherapy; Serum
alcohol in, 2019
alkali reserve after tribrom-ethanol anesthesia, 311
antiproteolytic factor in aborting women, [Shute] 747—ab; 1768—ab
Bacteria in: See also Septicemia; Tubercle Bacillus
bacteria in blood stream after tonsillectomy, [Fischer] 1432—ab
bilirubin, icterus index in new-born, [Bonar] 73—ab
bilirubin in biliary tract diseases, [Bengolea] 964—ab
bilirubinemia in cerebrospinal meningitis, [Katzmann] 256—ab
Cadaver: See Blood Transfusion
BLOOD—Continued
calcium, form in serum, 138
calcium, hypercalcemia (induced), [Lowenburg & Ginsburg] ★1779
calcium, hypercalcemia, simulating hyperparathyroidism, [Birk] 745—ab
calcium, hypocalcemia and loss of consciousness, [Kayser] 1770—ab
calcium, in arthritis, [Hartung & others] ★1448
calcium relation to magnesiemia after parathyroid injection, [Melli] 165—ab
carbonic anhydrase in pathologic states, [Hodgson] 1857—ab
carotene in normal and diabetics, [Ralli & others] ★1975; [Heymann] ★2050
Cell: See also Erythrocytes; Leukocytes
cell picture of tuberculous focal reaction, [Baar] 663—ab
changes after exertion at high altitudes, [Jezler] 2266—ab
chemistry of dog, 402
chlorides, hyperchloridemia (induced), [Mach] 2035—ab
chlorides, hypochloridemia (postoperative) vs. stagnant gastric content, [Antonucci] 1770—ab
chlorides in gastro-intestinal obstruction, [Voskresenskiy] 1694—ab
cholesterol, effect of nicotine on, [Strauss] 1237—ab
cholesterol in arthritis, [Hartung & others] ★1448
cholesterol in pregnancy, [Potter] ★1070; [Bartholomew] 2101—ab
cholesterol, relation to predisposition to skin cancer, [Roffo] 166—ab
cholesterolemia and arterial hyperpressure, [Domenech] 580—ab
Circulation: See also Arteries, coronary; Blood supply; Veins
circulation speed, measure by injecting ether and sodium dehydrocholate, [Godel] 1341—ab
circulation through skeletal muscle, [Anrep] 422—ab
circulation, velocity, effect of dinitrophenol on, [Wohl] 575—ab
clot culture an adjunct to Widal test, [Laybourn] 880—ab
clots, removal from bladder, 1940
coagulant extract from placenta for hemophilia, [Eley] 1422—ab
Coagulation: See also Blood clot
coagulation, cevitamic acid effect on, [Cotti] 1431—ab
coagulation, effect of typhoid vaccine and epinephrine on, [Simon] 419—ab
coagulation, physiology, 2249
colloidal osmotic pressure of serum after salt ingestion, [Torbert & Cheney] ★683
Conserved: See Blood Transfusion
Convalescent: See Measles
Count: See also Erythrocytes; Leukocytes
count, effects of aminopyrine and phenobarbital on, [Wilson] 420—ab
count, effects of artificial fever on, [Simon] 1042—ab
count in whooping cough, [Begg] 422—ab
count of dog, 402
counting chambers, Bass-Johns, 1223
Cyanates: See Blood thiocyanates
diastase, abnormal and blood sugar content, [Jorns] 1237—ab
Donor: See Blood Transfusion
Dry Blood Method of Chediak's: See Syphilis, serodiagnosis
dyscrasias after neoarsphenamine, [Cowper] 1426—ab
erythrocyte content during menstrual cycles, [Leverton & Roberts] ★1359
fats, provoked hyperlipemia and reticuloendothelial system, 2020
fibrin content of plasma in hepatic disease, [Geill] 504—ab
fibrinogen from, method for obtaining, [Kylin] 1434—ab
formation, hematopoiesis in fetus, [Wintrobe] 78—ab
formation, rôle of stomach in regulating, [Vlados] 1957—ab
group tests, admissible in court in evidence, New York, Wisconsin, 1180
group tests for paternity, [Smith] 559—C
guttadiaphot method, [Gulbin] 343—ab
hematologic reactions after arsphenamines, [Rich] 1765—ab
Hemoglobin: See Hemoglobin
histamine, chemical method for quantitative determination, 1755
in barbituric acid poisoning, 1215
in erysipelas, multiple serologic reactions, 1010—E
iodine, nicotine effect on, [Strauss] 1237—ab
lipoid (serum) in malnutrition, [Man] 1603—ab
magnesium after parathyroid injections, [Melli] 165—ab
morphologic changes in Hodgkin's disease, [Roth] 326—ab
occult, phenolphthalein test for, 1410
phosphatase (serum) in osteogenesis imperfecta, [Smith] 329—ab
phosphates, hypophosphatemia simulating hyperparathyroidism, [Birk] 745—ab

BLOOD—Continued
phosphorus, after parathyroid injections, [Melli] 165—ab
Picture: See also Blood cell
picture after splenectomy in children, [Wollstein] 2261—ab
picture, cytologic changes in myoma, [Vorlíček-Jelinek] 1614—ab
picture in metastatic cancer of bones, [Heck] 326—ab
picture in pulmonary tuberculosis, [Houghton] 80—ab
picture in x-ray and radium workers, [Kaplan] 1424—ab
picture (postoperative) in total stomach resection, [Tateno] 1771—ab
picture, vitamin C effect on, [Eufinger] 1236—ab
platelets after splenectomy, [Wollstein] 2261—ab
platelets, dinitrophenol poisoning with thrombocytopenia, [Imerman & Imerman] ★1085
platelets, effect of ephedrine on, [Simpson] 2196—ab
platelets in, distribution in peripheral blood, [Beecher] 968—ab
platelets, leukemia with thrombocytosis, [Drake] ★1005; [Kugelmass] 1588—C; (polycythemia?) [Dameshek] 1837—C
Preserved: See Blood Transfusion
proteins, alterations index of liver failure [Foley & others] 245—ab
proteins, hypoproteinemia, stasis albuminuria and cardiac edema, [Ehrström] 1434—ab
proteins in arthritis, [Davis] 1233—ab; [Hartung & others] ★1448
proteins, nitrogen distribution, hypertension classified by, [Rafsky] 1421—ab
Pus in: See Pyemia
regeneration and chlorophyll, 925—E
sedimentation rate (erythrocyte) in expansive disorders of brain, [Ask-Upmark] 1957—ab
sedimentation rate (erythrocyte) in psychoses [Gregory] 1854—ab
sedimentation rate in juvenile rheumatism, [Payne] 746—ab; 925—E; [Massell] 1679—C
sedimentation rate in tuberculosis, [Miller] 1952—ab
sedimentation reaction in cerebral tumor, [Abrahamsen] 426—ab
sedimentation reaction in coronary thrombosis, [Christensen] 2036—ab
sedimentation speed in pernicious anemia, [Reichel] 258—ab
sedimentation time in cardiac infarct, [Shookhoff] 1421—ab
sedimentation, 24 hour rhythm, [Jores] 965—ab
standards, normal, [Osgood] 159—ab
stream resistance in lungs, regulation of, 638
Sugar: See also Diabetes Mellitus
sugar and abnormal diastase values, [Jorns] 1237—ab
sugar and lactose in milk, [Tolstoi] 78—ab; 469—E
sugar and posterior pituitary principles, [Ellsworth] 2197—ab
sugar curves (daily) in healthy and diabetics, [Schöne] 258—ab
sugar, effect of alcohol, 2171
sugar, hyperglycemia and dementia paralytica, [Blackford] 1044—ab
sugar, hyperglycemia in coronary thrombosis, [Raab & Rabinowitz] ★1705
sugar, hyperglycemia, use of manganese in, 2182
sugar, hypoglycemia (infantile), [Neff] 1604—ab
sugar, hypoglycemia (spontaneous), bradycardia due to, [Ormond] ★1726; [Wortis] 2089—C
sugar, hypoglycemia with cretinism; thyroid treatment, [Costello] 1604—ab
sugar in hypertension, 637
sugar, increase during renal diseases, [Oefelein] 1862—ab
sugar, preoperative and postoperative, 230
sugar, relation to glycosuria, 307
sulfatemia in kidney disease, [Øilgaard] 2116—ab
supply (new) to heart, developed by operation, [Beck] 75—ab
supply of rat tumors, effect of stoppage, [Chambers] 1428—ab
Tests: See Blood group
thiocyanates, estimation in hypertension, [Barker] ★762
Tubercle Bacilli in: See Tubercle Bacillus
urea clearance, formula for determining, 484; (correction) 635
urea, hyperazotemia (postoperative) and stagnant gastric content, [Antonucci] 1770—ab
urea nitrogen by direct nesslerization, [Breuer] 421—ab
urea, nonurate azotemia and liver extract treatment, [Nonnenbruch] 580—ab
urea, postoperative nonprotein nitrogen retention, 1931
Velocity: See Blood circulation
Vomiting of: See Hematemesis
water concentration in pregnancy, [Oberst] 1037—ab
water content factor in anemia of pregnancy, [Feldman] 1761—ab
what sodium citrate solution is isotonic to? [Hirschlaff] 1434—ab

BLOOD PRESSURE, Arterial: See Blood Pressure, high
capillary (cutaneous), new method for determining, [Baumberger] 335—ab
changes in pregnancy, 2025
changes, significance, 1840
erythrocyte relation to, [Doles] 421—ab
estrogenic substance effect on, [Steinkamm] 1526—ab
fever therapy effect on, [Desjardins & others] ★697
high arterial, and cholesterolemia, [Domenech] 580—ab
high arterial, heat and posture in, 873
high arterial, peripheral resistance in, [Prinzmetal] 742—ab
high arterial, pressor substances in urine, [Capps] 159—ab
high arterial, rôle of endocrine glands in pathogenesis, 868
high, blood sugar in, 637
high, classification on nitrogen distribution of serum proteins, [Rafsky] 1421—ab
high, effect of hypertonic sucrose solution, [Murphy & others] 245—ab
high essential, operations on sympathetic in, [Adson] ★364
high essential, pregnancy in, [Albrecht] 425—ab
high, eye changes in hypertensive toxemia of pregnancy, [Hallum] ★1649
high, heart failure in, [Averbuck] 951
high, hypertensive cerebral attack, [McAlpine] 500—ab
high, hypertensive disease, 1839
high, hypertensive disease, tests used in studying, 484; (correction) 635
high, idiopathic, in pregnancy, 1029
high, in diabetes, [Root] 1039—ab
high, in thyrotoxicosis, [Maher & Sittler] ★1546
high, irradiation of adrenals, etc. 294—E; [Hutton] 1040—ab; [Hutton & others] 1753—C; [Rogoff] 1753—C
high malignant, [Derow] 162—ab
high, potassium or sodium thiocyanate for, [Barker] ★762
high, surgical treatment, [Adson] 1425—ab
increase, in adrenal stimulation, [Kuré] 2204—ab
intrapleural pressure (high) effect on, [Head] 159—ab
β methyl ζ-methylamino-β-γ-heptene effect on, [Jackson] ★359
pituitary pressor and oxytocic fractions effect on, [Melville] ★102
pituitary rôle in regulation, [Kylin] 342—ab
posture effect on tests for measuring, [Brown] ★354; ★356
reactibility, cold pressor test for measuring, [Brown] ★354, ★355; [Hines] 951—ab
sodium and potassium salts ingestion effect on, [McQuarrie] 1043—ab
variability, [Hoverson] 1950—ab
venous, effect of bath on, [Krüger] 752—ab
venous (peripheral) in schizophrenic and in normal, [Krinsky] 1125—ab
BLOOD TRANSFUSION, autotransfusion for wounds of heart, [Watson & Watson] ★520
conserved blood for, [Filatov] 84—ab
donor who has given 257 liters, 1507
donors, opsonocytophagic index for selecting, [Creswell & Wallace] ★1384
donors, regulation, Vienna, 1934
factors M and N in erythrocytes, [Blinov] 343—ab
fractionai, [Fonio] 2113—ab
gallbladder contractility after, [Bettman & Tannenbaum] ★1376
hemolytic shock after, 2241—E
immunotransfusion in undulant fever, [Creswell & Wallace] ★1384
in diphtheria, [Seckel] 425—ab
in empyema, [Schlegel] 1238—ab
in internal diseases, [Blumberger] 584—ab
in Italian Army, 309
in puerperal infection, [Erbslöh] 1238—ab
International Congress on (first), 309
nephritis complicating, [Tzanck] 81—ab
of cadaver blood, [Yudin] ★997
protein reaction (nonspecific) after, [Filatov] 1771—ab
syphilis transmitted by, [Mandelbaum & Saperstein] ★1061
uremia from, [DeGowin] 416—ab
BLOOD VESSELS: See also Arteries; Capillaries; Vasomotor Mechanism; Veins
changes in legs, 1592
disease, in obese diabetic, [Beck] 572—ab
disease (obliterating) in aged, 646
disease, Pavaex (passive exercise) treatment, [Conway] ★1153; [Wilson & Roome] ★1885; (Council accepts) 1986
disease, Pavaex (passive exercise unit) improved cuff for, [McKelvey] ★920
disease, peripheral, operations on sympathetic in, [Adson] ★360
disease, skin surface temperature as diagnostic method, [Bierman] ★1160
disease, treatment by motorized oscillating bed, [Sanders] ★916
Disorders: See Angioneurosis; Thrombo-Angiitis obliterans; etc.
eclampsia and, [Irving] 1761—ab
peripheral resistance in arterial hypertension, [Prinzmetal] 742—ab
BLOODGOOD, JOSEPH COLT, procedure for bone lesions, [Schrock] ★1884

BLUM'S Katechin: See Thyroid, antithyroid substance
BOARD: See American; National; Science Advisory Board
Basic Science: See Medical Practice Acts; Medicolegal Abstracts at end of letter M
BODY alcohol, carbon dioxide-oxygen inhalation to accelerate reduction, [Newman & Card] ★595
Build: See Constitution
Embalming: See Embalming
Growth: See Growth
Height: See Dwarfism; Giant
surfaces relation to orientation of venous valves, [Edwards] 1688—ab
Weight: See also Obesity
weight loss during night, 239
weight loss indicates surgical risk in peptic ulcer, [Studley] ★458
weight, loss of, muscular tension when at rest, 1638—ab
weight loss, prevention in psychoses, [Finkelman] 156—ab
BOECK Sarcoid: See Sarcoid
BOIL: See Abscess; Furunculosis; under Medicolegal Abstracts at end of letter M
BONDY Mastoidectomy: See Mastoidectomy
BONE MARROW: See also Myeloma; Sternum puncture
changes in agranulocytosis, [Darling] 1037—ab
culture; apparatus, [Osgood & Muscovitz] ★1888
depression after neoarsphenamine, [Cowper] 1426—ab
depression, clinical view, [Stevenson] 333—ab
"maturation arrest," in granulocytopenia, [Dameshek] 2177—C
reciprocal relation to myeloid and lymphoid tissues, [Wiseman & others] ★609
red, distribution, [Huggins] 325—ab
studies in infectious mononucleosis, [Freeman] 1947—ab
BONES: See also Cranium; Joints; Orthopedics; and under names of individual bones
Abscess: See Arthritis; Tibia
Ankylosis: See Temporomandibular Joint
as human food, 769—ab
atrophy, posttraumatic acute, [Gurd] 1126—ab
Block Operation: See Foot drop
Broken: See Fractures
cancer metastasis from stomach, [Kerr] 249—ab
cancer (metastatic), blood picture in, [Heck] 326—ab
cancer (metastatic), large doses of calcium in, [Brunschwig] 737—ab
cancer; sarcoma, pathologic fractures due to, [Welch] 1953—ab
changes in march foot, [Maseritz] 656—ab
cyst, malignant degeneration, [Francisco] 1851—ab
deformed, in spite of vitamin D, 704—ab
diet (restricted) effect on, 55
Disease: See also Osteitis; Osteomyelitis
disease and parathyroids, 1566—E
disease, urinary calculi in, 469—E
echinococcosis, diagnosis, [Ivanissevich] 1135—ab
forceps, fulcrum for, [Lusskin] ★918
formation (heterotopic) from urinary tract epithelium, [Lucinesco] 2035—ab
Fractures: See Fractures
fragility, nature, [Puppel] 329—ab
fragility, serum phosphatase in, [Smith] 329—ab
graft eventually becomes rarefied, 392
graft (massive onlay) of upper extremity, [West] 1130—ab
graft to increase diameter of contracted pelvis, 2017
inflammations (late) of war, treatment, [Sarroste] 580—ab
lesions, Bloodgood's rules of procedure, [Schrock] ★1884
softening, roentgen changes, [Camp] 2198—ab
statistical data on human skeleton, 487
tuberculosis, experimental, 1582
tuberculosis, Gauvain's treatment, 1929
tuberculosis, surgical treatment, 1215
tumors, 138
tumors, diagnostic difficulties; correlating societies for data on sarcoma, [Schrock] ★1882
union, factors modifying, 485
BONNIE Brand Hawaiian pineapple, 1387
Farms Brand Evaporated Milk, 1899
BOOKS: See also Bibliography; Library; Book Notices at end of letter B
Carnation Cook Book, 1473
exhibit (of old works, Bologna) 230; (of rare books, Australia) 554
BOOTH'S Hyomei, 1111—BI
BORASH, 143—BI
BORDEN'S (evaporated milk), 293; (malted milk), 782
BORDEN Memorial Lectureship established, 2164
BOTELHO'S Reaction: See Uterus cancer
BOTRYOMYCOSIS: See Granuloma pyogenicum
BOTULISM: See also Food poisoning; Medicolegal Abstracts at end of letter M
Botulinus Antitoxin, N.N.R., for prophylaxis and treatment, 1165

BOTULISM—Continued
Clostridium botulinum, limber neck in chickens, 1027; (reply) [Murray] 1682
outbreak from home canned peppers, New Jersey, [Caprio] ★687
BOUGIENAGE: See Esophagus, acute corrosion
BOWMAN-VISSCHER Method: See Pregnancy diagnosis
BRACE for handling patients with cervical vertebrae injuries, [Wright] ★1467
used in knee joint dislocation, [Conwell & Aldredge] ★1255
BRADY, WILLIAM, dangers of self-treatment with iodine, 1116
BRADYCARDIA due to spontaneous hypoglycemia, [Ormond] ★1726; [Wortis] 2089—C
of digestive origin, 1746
BRAGG, PAUL C., 1408—BI
BRAIN: See also Cranium; Head; Hydrocephalus
angiography, clinical results 1749
concussions (mild), results, [Reuter] 1956—ab
disorders, expansive, sedimentation rate (erythrocyte) in, [Ask-Upmark] 1957—ab
edema, effect of fluid intake on epilepsy, 1412
encephalography, sympathetic disturbances after, [Boeters] 663—ab
encephalography with anesthetic gases, [Aird] 1126—ab
fissure, mark on head indicating position of, [Bértola] 1047—ab
hemorrhage, auricular fibrillation with apoplexy, [Perkins] 2262—ab
hemorrhage, Duret, are they diapedesis hemorrhages? [Berner] 1864—ab
hemorrhage, etiology, 477
hemorrhage, hemorrhagic purpura with, [Garvey] 880—ab
hemorrhage in basal ganglions in heterophyidiasis, [Africa] 1605—ab
hemorrhage in new-born, [Galloway] ★505
hemorrhage, intramuscular autohemotherapy for [Colella] 335—ab; 1412
hemorrhage, problem of spastic child, [Brockway] ★1635
hemorrhage, spontaneous intracerebral, [Craig] 2103—ab
hemorrhage with paralysis; treatment, 1412
hypertensive attack, [McAlpine] 500—ab
injuries due to external trauma, [Swift] 1425—ab
leukodystrophy (progressive hereditary of Merzbacher-Pelizaeus), [Forsberg] 1864—ab
of children, study, [Tuthill] 1850—ab
roentgen study of vessels by injecting thorotrast into carotid artery, [Loman] 1599—ab
surgery, occipital lobectomy effect on vision, [Spence] 2199—ab
symptoms in acute myocardial infarction, [Kjærgaard] 1957—ab
Syphilis: See Neurosyphilis
tumor (congenital) in third ventricle; encephalography or ventriculography, [Davidoff] 333—ab
tumor, convulsions in diagnosis, [Sachs] 1854—ab
tumor in children, [Scott] 879—ab
tumor, mesencephalic glioma, [Alpers] 419—ab
tumor of temporal lobe, lift reaction as aura in, [Hoff] 2267—ab
tumor of temporal lobe, mental symptoms in, [Keschner] 1949—ab
tumor, roentgen treatment of gliomas, [Sachs] 1949—ab
tumor, sedimentation reaction in, [Abrahamsen] 426—ab
tumor, ultimate surgical results, Yale collection, 1901—E
ventricle (fourth), 201—ab
ventricle (third), floor of, 1438—ab
ventricular puncture before operation for petrositis, [Rosen] 1040—ab
ventriculography, dangers, 2072—E
ventriculography with colloidal thorium dioxide, [Freeman & others] ★96
BRANCHIOMA, sternoclavicular, [Fried] 737—ab
BRAZILIAN Congress of Cancer (first), 311; 1583
BREAKFAST Cereal: See Cereals
BREAST: See also Lactation
abscess, incision; aspiration, sodium hypochlorite solution irrigation, [Battle] 1608—ab
cancer and sexual cycle in mice, [Burns] 951—ab
cancer in male, [Davis & others] ★1359
cancer, irradiation of ovaries and also pituitary in, 944; (reply) [Simmons] 1515; 1594; [Hill] 1940
cancer, large doses of calcium in metastases to bone, [Brunschwig] 737—ab
cancer, pathogenesis, 2080
cancer, produced by painting skin with estrogenic substance, [Cramer] 1768—ab
cancer, treatment, 59
Cystic Mastitis: See Breast inflammation
cystic mastopathy, estrogenic substance treatment, [Dahl-Iversen] 1138—ab
Feeding: See Infants
gynecomastia, 1224; [Goldman] 2268—ab
hypertrophy, 67
Inflammation: See also Udders
inflammation (chronic cystic), [Horwitz] 1423—ab
BREAST—Continued
inflammation (chronic) relation to ovary and pituitary hormones, [Taylor] 1606—ab
inflammation (chronic), with gynecologic lesions, [Taylor] 1045—ab
lactogenic substance in, [Geschickter] 1851—ab
mammary gland reaction to estrogenic substance percutaneously, [Zondek] 423—ab
Milk: See Milk, human
pain and tenderness, 562
painful, preceding menstruation, [Taylor] 1045—ab
pendulous, reconstruction, [Thorek] 1950—ab
soreness, 101—ab
tumor, sarcoma in male and female, [Rose] 966—ab
BREECH Presentation: See Labor
BREEDEN'S Rheumatic Compound, 143—BI
von BREHMER'S Siphonospora polymorpha: cause of cancer publicized, 394
BRIGGS' Thermo Theraputor, 122
BRILLIANT GREEN: See Leprosy treatment
BRITISH: See also Royal
Academic Assistance Council: See Jews
Medical Association, (annual meeting at Melbourne) 58; 137; (invite A. M. A. representatives) 861
Red Cross: See Red Cross
*tri*BROM-ETHANOL: See Anesthesia
BROMIDE, Peacock's, coma of 4 months' duration from, [Craven & Lancaster] ★1383
BRONCHIECTASIS, climate for, 727
diagnosis (early), clinical and roentgen study, [Farrell] ★92
BRONCHITIS, chronic, with emphysema and right ventricular failure, 317
treatment, climatic, 727; 1841
BRONCHOGRAPHY, use of iodized oil in, 1412
BRONCHOPNEUMONIA, suitable climate for child with, 147
BRONCHOSCOPY: See Lungs, abscess
BRONCHUS cancer, [Rosedale] 1847—ab
cancer and tuberculous stenosis, [Fleischner] 1861—ab
factor in Ayerza's disease, [Castex] 1692—ab
infection (chronic) in child, climate for, 147
BROWN-PEARCE Rabbit Epithelioma: See Epithelioma
Tumor: See Tumors
BRUCELLA Abortus Infection: See Abortion, contagious; Undulant Fever
BRUCELLOSIS: See Undulant Fever
BRUSSELS medical convention, 868
BUERGER'S Disease: See Thrombo-Angiitis obliterans; Medicolegal Abstracts at end of letter M
BUILDING: See also American Medical Association
daylight in, 126—E
BULGARIAN Marvel Herb Tea Compound, 1337—BI
BULLAE: See Psoriasis
BULLET, wandering, in spinal canal, [Pilcher] 1690—ab
BUNGE Research Institute, 869
BURDICK Radiant Heat Lamp, 781
BUREAU: See also Press Bureau
A. M. A. See American Medical Association of Human Heredity, 2247
of Medical Relations with Foreign Countries (Paris), 1828
to combat violation of antinarcotic laws, Germany, 638
BURNING Sensation: See Mouth; Tongue
BURNS, ammoniated mercury ointment cause of, 1938
as cause of diabetes, 2256
phosphorus cause of, treatment, [Starz] 884—ab
treatment, cod liver oil, [Iost] 586—ab
treatment, tannic acid, disadvantages; advocates mercurochrome, [Turner] 500—ab
treatment, tannic acid, misuse, [Taylor] ★1144
BUSCO, JUAN, death, 1510
BUSSON, BRUNO, death, 1216
BUTTER: See Peanut Butter
Substitutes: See Oleomargarine
BUTYL-PARA-AMINOBENZOATE: See Anesthesia, oil-soluble
BYRD'S Vapor Salve, 143—BI
BYRON Herb Tablets, 143—BI

BOOK NOTICES

Absorption Spectra, Application to Study of Vitamins and Hormones, 1517
Accidents, Injury and Incapacity; Industrial Insurance, 408
Acidophilus, Lactobacilius Acidophilus and Its Therapeutic Application, 648
Actinomyces Group, Pathogenic Aerobic Organisms of, 948
Adams County, Illinois, Folklore from, 152
Aichhorn, A., Wayward Youth, 70
Akerrén, A. Y., Experimental Changes in Liver Function, 2184
Alcalá Santaella, D. R., Los fundamentos científicos y la práctica de la educación física, 2029
Alcohol, Stop-Light, 734
Alexander, F., Roots of Crime, 241
Alsted, G., Experimentelle undersøgelser over bartonellaanaemi hos rotter og mus, 1944
Amebiasis, Experimentelle Untersuchungen über Amöbenruh, 566; 650
American Association of Medical Social Workers, Medical Social Work, 1119
American Medical Association, Glandular Physiology and Therapy, 1595
American Pharmaceutical Association, National Formulary, 2184
Anatomy, Atlas of Pathological Anatomy (Martin), 409
Anatomy, Atlas (Williams), 1227
Anatomy, Introduction (Marshall), 409
Anatomy of Personality, 1942
Anatomy of the Rat, 1844
Anderson, A. K., Essentials of Physiological Chemistry, 243
Androp, S., Probability of Commitment for Mental Disorder, 1596
Anemia, Experimentelle undersøgelser over bartonellaanaemi hos rotter og mus, 1944
Angines lympho-monocytaires, agranulocytoses, leucémies leucopéniques, 409
Anomalii rosta i razvitiya, 1227
Anthropological Compendium; Woman, 733
Arteries, peripheral, Diagnosis and Treatment of Diseases, 1757
Arthropometry, Growth of Surface Area of Human Body, 567
Arzt, L., editor, Die Haut- und Geschlechtskrankheiten, 734
Astéréognosies: Pathologie du toucher, 732
Australian Cancer Conference (sixth), 734
Automobile and Gasoline Engine Encyclopedia (Dyke's), 1226
Autopsies, Post Mortems and Morbid Anatomy 1517
Bacillus, Lactobacillus Acidophilus and Its Therapeutic Application, 648
Bacteriological Grading of Milk, 1844
Bacteriology, Elementary (Greaves), 2187
Bacteriology, Handbook (Bigger), 650
Bacteriology of Typhoid, 876
Bacteriology, Principles (Eisenberg-Huntly), 567
Bacteriology, Textbook (Jordan's), 152
Bacteriology, Textbook (Rice's), 491
Bailey, H., Demonstrations of Physical Signs in Clinical Surgery, 567
Bargen, J. A., Management of Colitis, 566
Bartlett, H. M., Medical Social Work, 1119
Bartonella, Experimentelle undersøgelser over bartonellaanaemi hos rotter og mus, 1944
Bauer, K. H., Die Praxis der Sterilisierungsoperationen, 1035
Baumgartner, L., Bibliography of the Poem Syphilis Sive Morbus Gallicus, 68
Beaman, A. G., Doctor's Odyssey: Sentimental Record of Le Roy Crummer, 1943
Beauty, Awaken Your Sleeping Beauty, 243
Beck, A. C., Obstetrical Practice, 648
Beer, E., Tumors of Urinary Bladder, 1417
Behavior Development in Infants, 1416
Behavior, Glands and Efficient Behavior, 877
Benedetti-Pichler, A. A., Introduction to Microtechnique of Inorganic Qualitative Analysis, 1944
Bertholdt, F., Der chirurgische Operationssaal, 70
Beverage, Food and Beverage Analyses, 321
Bieling, R., Experimentelle Untersuchungen über Amöbenruh, 566
Bigger, J. W., Handbook of Bacteriology, 650
Bile Ducts, Diseases, 732
Bio-Chemistry, Clinical, 242
Biochemistry, Fundamentals in Relation to Human Physiology, 948
Biochemistry of Lipids, 949
Biochemistry, Précis de chimie biologique médicale, 649
Biological Politics: Aid to Clear Thinking, 243
Biopsychology, Manuali pratici di medicina biopsicologica, 408
Bladder, Tumors, 1417
Blanton, S., For Stutterers, 1597
Blood, Appareil circulatoire, 492
Blood, Blutkörperchensenkung, 2186
Blood, Cerebrospinal Fluid and Its Relation to, 1597
Blood Groups, International Bibliography on Theory of, 650
Blood Pressure, Diagnosis and Treatment of Variations, 241
Blood Pressure, High Blood Pressure and Its Common Sequelae, 875
Blood Pressure, high, Cardiac Output and Arterial Hypertension, 877
Blood Pressure, high, Die Seelenstörungen der Blutdruckkranken, 949
Blood Transfusion, International Bibliography on Problems, 650
Blumer, G., Practitioners Library of Medicine and Surgery, 1943
Body, Growth of Surface Area, 567
Body Water: Exchange of Fluids in Man, 1033
Body, Width-Weight Tables, 2029
Bogomoltsa, A. A., editor, Osnovy i dostizheniya sovremennoy meditsiny, 1120
Bolgert, M., Lésions du pancréas et troubles fonctionnels pancréatiques, 2258
Bones, Localized Rarefying Conditions, 566
Bones, Radiology, 242
Bones, Tuberculose ostéo-articulaire, 947
Bostroem, A., editor, Sammlung psychiatrischer und neurologischer Einzeldarstellungen, 150; 492
Boyd, E., Growth of the Surface Area of Human Body, 567

Book Notices—Continued
Boyd, W., Pathology of Internal Diseases, 151
Bradshaw Lectures of 1934, Haemochromatosis, by J. H. Sheldon, 1684
Brailsford, J. F., Radiology of Bones and Joints, 242
Breast, Données anatomiques en vue de la chirurgie réparatrice mammaire, 1336
Bridges, M. A., Food and Beverage Analyses, 321
British Pharmaceutical Codex, 1934, 1336
Brugsch, T., Lehrbuch der inneren Medizin, 1416
Bull, H. B., Biochemistry of the Lipids, 949
Burns, Modern Treatment, 1227
Butter, Vitamin A Content, 321
Cabot, R. C., Art of Ministering to the Sick, 2259
Calvé, J., La tuberculose ostéoarticulaire, 947
Campbell, A., Oxygen and Carbon Dioxide Therapy, 949
Campbell, C. M., Destiny and Disease in Mental Disorders, 948
Campbell, C. M., Human Personality and Environment, 1336
Canadian Medical Association, History, 2028
Cancer, Imperial Cancer Research Fund, Report, 2096
Cancer, Report of the Sixth Australian Cancer Conference, 734
Cancer, Teoria de los neoplasmas, 1759
Cancer, Über die formale Genese des Lungenkrebses, 2097
Capillaries, Die seröse Entzündung: Eine Permeabilitäts-Pathologie, 567
Carbon Dioxide Therapy, 949
Carmichael, F. A., Guide to Psychiatric Nursing, 2258
Castration chez l'homme et les modifications morphologiques qu'elle entraine, 493
Cerebrospinal Fluid and its Relations to Blood, 1597
Chamberlain, E. N., Text-Book of Medicine for Nurses, 1517
Chandler, A. C., Introduction to Human Parasitology, 2097
Charaka Club, Proceedings, 321
Chemistry, Clinical and Pathological Applications of Spectrum Analysis, 1035
Chemistry, Introduction to Microtechnique of Inorganic Qualitative Analysis, 1944
Chemistry, Kolloid-Fibel für Mediziner, 2187
Chemistry, Physiological, Essentials, 243
Chemistry, Popoff's Quantitative Analysis, 1035
Chesser, E. S., Vitality, 321
Child Nutrition on a Low-Priced Diet, 242
Children, Delinquent Boy and the Correctional School, 150
Children, Diseases of, 242
Children, Growing Superior, 947
Children, Schoolboy, 242
Children, Social Problems of High School Boy, 651
Children, Speech in Childhood, 151
Children, Width-Weight Tables, 2029
Children, Your Child in Health and in Sickness, 2027
Chompret, La pratique stomatologique, 1417
Christian, H. A., Diagnosis and Treatment of Diseases of the Heart, 70
Christopher, F., editor, Textbook of Surgery, 2097
Cifuentes, P., La litiasis reno-ureteral bilateral, 2259
Circulatory System, Appareil circulatoire, 492
Claoué, C., Association pour la documentation photographique et cinématographique dans les sciences, 1335
Claoué, C., Données anatomiques en vue de la chirurgie réparatrice mammaire, 1336
Clayton, W., Theory of Emulsions and Their Technical Treatment, 946
Clinical Bio-Chemistry, 242
Colebrook, D. C., Source of Infection in Puerperal Fever Due to Haemolytic Streptococci, 1683
Coleman, E. M., Diabetic Primer for Children, 2029
Colitis, Management of (Bargen), 566
Colloids, Kolloid-Fibel für Mediziner, 2188
Commonwealth Fund, Lobar Pneumonia, 2258
Consciousness, Pathopsychologie der Gefühle und Triebe: Ein Grundriss, 2029
Consumers' Research, Eat, Drink and Be Wary, 650
Convalescent Care in Great Britain, 1597
Corlett, W. T., Medicine-Man of the American Indian, 70
Cosmetics, Haarkrankheiten und kosmetische Hautleiden, 1033
Crile, G., Phenomena of Life: A Radio-Electric Interpretation, 1226
Crime, Roots of: Psychoanalytic Studies, 241
Cristol, P., Précis de chimie biologique médicale, 649
Crossen, H. S., Diseases of Women, 947
Crummer, Le Roy, Doctor's Odyssey, 1943
Crystals, Mikroskopische Methoden in der Mikrochemie, 948
Delay, J. P. L., Les astéréognosies, 732
Delinquency, Wayward Youth, 70
Delinquent Boy and Correctional School, 150
Dementia Praecox, Destiny and Disease in Mental Disorders, 948
Dentistry, history of, Die Zahnheilkunde im achtzehnten Jahrhundert, 1119
Dentistry, Text-Book of Surgery for Dental Students, 1119
de Rivas, D., Clinical Parasitology and Tropical Medicine, 68
Dermatology, Die Haut- und Geschlechtskrankheiten, 734
Dewey, E., Behavior Development in Infants, 1416
Dewey, M., Practical Orthodontia, 1033
Diabetes Mellitus, Food for the Diabetic, 1517
Diabetes Mellitus, Primer for Children, 2029
Diabetes Mellitus, Treatment (Joslin), 1334
Diagnosis, Demonstrations of Physical Signs in Clinical Surgery, 567
Diagnosis, Index of Main Symptoms, 1844
Diagnosis, Special Procedures, 409
Diathermy, Die physikalischen und technischen Grundlagen der Hochfrequenzbehandlung, 320
Diathermy, Foundations of Short Wave Therapy (Holzer-Weissenberg), 2028
Diathermy, Short Wave Therapy (Schliephake), 320
Diathermy, Short Wave Therapy (Wolf), 2028
Diet, Alimentación y dietética, 2259
Diet and Die, 1945
Diet and Physical Efficiency, 875
Diet, Child Nutrition on Low-Priced Diet (Rose), 242
Diet, Classified Bibliography on Psychodietetics, 71
Diet, Food and Beverage Analyses, 321
Diet, Food Values at a Glance and How to Plan a Healthy Diet, 1120
Diet Manual of University Hospital, Michigan, 2259
Diet Manual, St. Mary's Hospital, 877
Diet, Nahrungsmitteltabelle zur Aufstellung und Berechnung von Diätverordnungen, 1945
Diet, You Must Eat Meat, 1944
Digestion, Pathologie digestive, 2260
Digitalis, 1595
Diphtheria, La diphtérie maligne, 409
Disease, Agents and Host Resistance, 1034
Disease, Geography of Disease, 1517
Doctor of the North Country, 2097
Doctor's Odyssey, 1943
Dodge, C. W., Medical Mycology, 2027
Dressler, W., Atlas der klinischen Elektrokardiographie mit Anleitungen zur Differentialdiagnose, 2096
Drugs, Incompatibility in Prescriptions, 243
Dublin, L. I., Length of Life, 1118
Dwyer, H. L., Your Child in Health and in Sickness, 2027
Dyke, A. L., Automobile and Gasoline Engine Encyclopedia, 1226
Dysentery Infections and Carrier States, 876
East, T., Recent Advances in Cardiology, 2186
Eat, Drink and Be Wary, 650
Eclampsia, Traitement de l'éclampsie, 242
Eden, T. W., Gynaecology, 2186
Education, Creative Re-Education, 2029
Ehrlich, Paul, Those Were Good Days! 2260
Eisenberg, A. A., Principles of Bacteriology, 567
Electrotherapy and Light Therapy, 492
Electro-Therapy, General, 2028
Ellis, H., Studies in the Psychology of Sex, 2098
Emulsions, Theory of Emulsions and Their Technical Treatment, 946
Encyclopedia: Dyke's Automobile and Gasoline Engine Encyclopedia, 1226
Endocrine Therapy, Glandular Physiology and Therapy, 1595
Endocrine Tumours, and Other Essays, 2259
Endocrinology, A B C of the Endocrines, 876
Glands and Efficient Behavior, 877
Endocrinology, Lehrbuch der Endokrinologie, 1335
Endocrinology, Les acquisitions nouvelles de l'endocrinologie, 152
Environment, Human Personality and, 1336
Enzymes, Die Fermente und ihre Wirkungen, 947
Eppinger, H., Die seröse Entzündung: Eine Permeabilitäts-Pathologie, 567
Erikson, D., Pathogenic Aerobic Organisms of Actinomyces Group, 948
Exercises, Individual Exercises, 321
Eyes, Radium Treatment of Diseases, 649
Face, Restauration et prothèse maxillo-faciales, 651
Fasciae of Human Body, 949
Fenton, N., Delinquent Boy and the Correctional School, 150
Fever, Electropyrexia in General Paralysis, 1226
Fishbein, M., editor, Handbook of Therapy, 243
Fishbein, M., editor, National Medical Monographs (Bargen), 566
Folk-Lore from Adams County, Illinois, 152
Food and Beverage Analyses, 321
Food and Health, 2029
Food fads, Diet and Die, 1945
Food, Nahrungsmitteltabelle zur Aufstellung und Berechnung von Diätverordnungen, 1945
Food Values at a Glance, 1120
Foot, 1685
Foot, Human Foot: Evolution, Physiology and Functional Disorders, 1516
Forensic Medicine: Text-Book, 150
Formulary, National Formulary, VI, 2184
Formulary of University (of Michigan) Hospital, 1596
Forsgren, E., Über die Rhythmik der Leberfunktion, des Stoffwechsels und des Schlafes, 1120
Fox, R. F., Chronic Rheumatism, 1843
Fracastorius, Bibliography of the Poem Syphilis Sive Morbus Gallicus, 68
Fractures, Text-Book (Speed), 241
Frank, C., L'immunità acquisita mediante l'educazione psichica integrale, 408
Frank, C., Manuali pratici di medicina biopsicologica, 408
French, H., editor, Index of Differential Diagnosis of Main Symptoms, 1844
Freud, A., Psycho-Analysis, 1758
Friend, G. E., Schoolboy, 242
Fritz, M. F., Classified Bibliography on Psychodietetics, 71
Fungi, Medical Mycology, 2027
Gaddum, J. H., Gefässerweiternde Stoffe der Gewebe, 1684
Gallbladder, Diseases; Diagnosis and Treatment, 732
Gardiner, E. G., Convalescent Care in Great Britain, 1597
Gastro-Enterology, Pathologie digestive, 2260
Gastro-Intestinal Tract, Manuel de coprologie clinique, 1035
Gay, F. P., Agents of Disease and Heat Host Resistance, 1034
Genetics, 321
Geopsyche, 2258
Gerhartz, H., Multiple Sklerose und Tuberkulose, 152
Gerlach, W., Clinical and Pathological Applications of Spectrum Analysis, 1035
Germany, Those Were Good Days! 2260
Gins, H. A., Beiträge zur Pathogenese und Epidemiologie der Infektionskrankheiten, 70
Gladstone, S. A., Cardiac Output and Arterial Hypertension, 877
Glandular Physiology and Therapy, 1595
Glasscheib, S., Allgemeine Röntgenkunde, 1684
Glasses, Modern Ophthalmic Lenses and Optical Glass, 2186
Goiffon, R., Manuel de coprologie clinique, 1035
Goodwin, G. M., Russell A. Hibbs, 1869-1932, 321
Greaves, J. E., Elementary Bacteriology, 2187
Greene, E. C., Anatomy of Rat, 1844
Gregory, J., A B C of the Endocrines, 876
Griffiths, H. E., Injury and Incapacity, 408
Guggenheim, L. K., Otosclerosis, 1683
Guillain, G., Études neurologiques, 1844
Gunewardene, H. O., High Blood Pressure and Its Common Sequelae, 875
Guthrie, D., Speech in Childhood, 151
Gynaecology (Eden & Lockyer), 2186
Gynecology, Diseases of Women (Crossen), 947
Gynecology, Lehrbuch der Gynäkologie, 876
Gynecology, Practical Handbook (Haultain), 1120
Gynecology, Woman: Historical Compendium, 733
Haemochromatosis, 1684
Haggard, H. W., Anatomy of Personality, 1942
Haggard, H. W., Diet and Physical Efficiency, 875
Haggard, W. D., Surgery, 1845
Hair and Scalp: Clinical Study, 1944
Hair, Haarkrankheiten und kosmetische Hautleiden, 1033
Halsey, R. H., How the President, Thomas Jefferson, and Doctor Benjamin Waterhouse Established Vaccination, 2259
Hammond, T. E., Infections of the Urinary Tract, 243
Handbook of Therapy, 243
Harrison, B. J. M., Textbook of Roentgenology, 2186
Harvier, P., Pathologie digestive, 2260
Hathaway, I. L., Vitamin A Content of Butter, 321
Haultain, W. F. T., A Practical Handbook of Midwifery and Gynaecology, 1120
Hauser, Benjamin, Diet and Die, 1945
Havens, L. C., Bacteriology of Typhoid, Salmonella and Dysentery Infections and Carrier States, 876
Hawes, J. B., Jr., Diagnosis and Treatment of Pulmonary Tuberculosis, 2095
Hawk, P. B., Streamline for Health, 243
Hay, William Howard, Diet and Die, 1945
Head Injuries, 946
Health and Food, 2029
Health and Human Progress, 1415
Health, Don't Believe It! Says the Doctor, 2029
Health, Introduction to Public Health, 491
Health of Women and Children, Vitality, 321
Health, Streamline for, 243
Health, Your Child in Health and in Sickness, 2027
Heart, Atlas der klinischen Elektrokardiographie mit Anleitungen zur Differentialdiagnose, 2096
Heart, Cardiac Output and Arterial Hypertension, 877
Heart, Diagnosis and Treatment of Diseases, 70
Heart disease, Digitalis, 1595
Heart, Essentials of Cardiography, 949
Heart, Recent Advances in Cardiology, 2186
Heart, Semiología radiológica de la auricula izquierda, 1845

Book Notices—Continued
Heffter, A., editor, Handbuch der experimentellen Pharmakologie, 1034
Hellpach, W., Geopsyche, 2258
Henry, G. W., Essentials of Psychopathology, 2098
Heredity, Probability of Commitment for a Mental Disorder, 1596
Hibbs, Russell A., Pioneer in Orthopedic Surgery, 1869-1932, 321
Hindley-Smith, J. D., Chronic Streptococcal Toxemia and Rheumatism, 1118
Hines, D. C., Special Procedures in Diagnosis and Treatment, 409
Hinsie, L. E., Electropyrexia in General Paralysis, 1226
Hirschfeld, M., Men and Women, 321
Hoche, A. E., Aus der Werkstatt, 567
Holzer, W., Foundations of Short Wave Therapy, 2028
Hormones, Application of Absorption Spectra, 1517
Hospital, Diet Manual, St. Mary's, 877
Hospital Organization and Management, 69
Hospital Yearbook, 1845
Howe, E. G., I and Me, 1685
Huddleson, M. P., Food for the Diabetic, 1517
Hutchinson, R., For and Against Doctors: An Anthology, 1944
Hutt, C. W., editor, Principles and Practice of Preventive Medicine, 2187
Hyatt, H. M., Folk-Lore from Adams County, Illinois, 152
Hygiene, Principles, 2097
I and Me: Study of Self, 1685
Ileum, Beitrag zur Kenntnis des Ileum terminale fixatum und Ileus ilei terminalis fixati, 69
Immunità acquisita mediante l'educazione psichica integrale, 408
Immunology, Agents of Disease and Host Resistance, 1034
Immunology (Sherwood), 152
Imperatori, C. J., Diseases of the Nose and Throat, 320
Imperial Cancer Research Fund, Report, 2096
Indian, Medicine-Man, 70
Industrial Disease, Epidemiology of Pneumonia on the Witwatersrand Goldfields, 733
Industrial Insurance, Injury and Incapacity, 408
Industrial Productivity, Diet and Physical Efficiency, 875
Infants, Behavior Development, 1416
Infants mortality, Der Geburstod (Mutter und Kind), 565
Infants, Mother and Baby Care in Pictures, 409
Infants, Nutrition of Mother and Child, 321
Infections of Urinary Tract, 243
Infectious Diseases, Beiträge zur Pathogenese und Epidemiologie, 70
Infectious Diseases, Études expérimentales récentes sur les maladies, infectieuses, 2187
Infectious Disease, Thérapeutique médicale, 2185
Inman, F. W., Biological Politics, 243
Instinct, Pathopsychologie der Gefühle und Triebe, 2029
Insurance, industrial, Injury and Incapacity, 408
Insurance, social, International Labour Organisation and, 1843
Internal Diseases, Pathology, 151
Internal Medicine, Lehrbuch der inneren Medizin, 1416
International Bibliography on Blood Transfusion and Blood Groups, 1900-1933, 650
International Labour Organisation and Social Insurance, 1843
International League Against Rheumatism, 1843
International Medical Annual, 492
Intestines, Beitrag zur Kenntnis des Ileum terminale fixatum, 69
Irving, F. C., Textbook of Obstetrics, 2185
Jaffe, B., Outposts of Science, 2030
Jastrow, J., Sanity First, 491
Jaws, Restauration et prothèse maxillo-faciales, 651
Jefferson, Thomas, How the President, and Doctor Benjamin Waterhouse Established Vaccination, 2259
Jenkins, H. P., Terminology of Operations of University of Chicago Clinics, 409
Jennings, H. S., Genetics, 321
Joints, Radiology, 242
Joints, Tuberculose ostéo-articulaire, 947
Jordan, E. O., Textbook of General Bacteriology, 152
Joslin, E. P., Treatment of Diabetes Mellitus, 1334
Jutte, M. E., You Must Eat Meat, 1944
Katzenelbogen, S., Cerebrospinal Fluid and Relation to the Blood, 1597
Kelley, I. V., Textbook of Nursing Technique, 1759
Kemp, T., Lehrbuch der Endokrinologie, 1335
Kerr, D. J. A., Forensic Medicine, 150
Kidney, La litiasis reno-ureteral bilateral, 2259
King, E. S. J., Localized Rarefying Conditions of Bone, 566
Knowles, F. C., Diseases of Skin, 1120
Köhler, A., Röntgenology: Normal and Early Pathological in the Skiagram, 1596
Koenig, E., editor, International Bibliography on Blood Transfusion and Blood Groups, 650
Kofler, L., Mikroskopische Methoden in der Mikrochemie, 948
Kovács, R., Electrotherapy and Light Therapy, 492
Krapf, E., Die Seelenstörungen der Blutdruckkranken, 949
Krout, M. H., Autistic Gestures, 2096
Künkel, F., Grundzüge der praktischen Seelenheilkunde, 321
Kugelmass, I. N., Growing Superior Children, 947
Laboratory Diagnosis of Tropical Diseases, 2259
Lactobacillus Acidophilus and its Therapeutic Application, 648
Ladue, W., Square Deal for Narcotic Addict, 1843
Lake, N. C., Foot, 1685
de Langen, C. D., Clinical Text-Book of Tropical Medicine, 1942
Laryngology, Recent Advances, 1118
Laubry, C., Appareil circulatoire, 492
Laurens, G., Chirurgie de l'oreille, du nez, du pharynx et du larynx, 1845
Lauwers, E. E., Introduction à la chirurgie thoracique, 321
Lejars, F., Traité de chirurgie d'urgence, 1416
Liesegang, R. E., Kolloid-Fibel für Mediziner, 2188
Life, Length of Life, 1118
Life, Phenomena of Life, 1226
Life, Sanity First: Art of Sensible Living, 491
Light Therapy and Electrotherapy, 492
Lindberg, K., Über die formale Genese des Lungenkrebses, 2097
Lipids, Biochemistry, 949
Lister, S., Epidemiology of Pneumonia on the Witwatersrand Goldfields, 733
Literature, For and Against Doctors; Anthology, 1944
Liver, Diseases, Diagnosis and Treatment, 732
Liver Function, Experimental Changes; Diagnosis, 2184
Liver function, Über die Rhythmik der Leberfunktion, 1120
Loeper, M., Thérapeutique médicale, 2185
Longevity, Length of Life: Study of the Life Table, 1118
Lord, F. T., Lobar Pneumonia and Serum Therapy, 2258
Lung, Über die formale Genese des Lungenkrebses, 2097
Lyster, A. M., Social Problems of the High School Boy, 651
McComb, E. V., Doctor of the North Country, 2097
MacDermot, H. E., History of Canadian Medical Association, 1867-1921, 2028
Macdonald, G., Osteopathic Lesion, 1417
MacEachern, M. T., Hospital Organization and Management, 69
McKinley, E. B., Geography of Disease, 1517
McLester, J. S., Diagnosis and Treatment of Disorders of Metabolism, 152
Malamud, W., Outlines of General Psychopathology, 651
Malaria, Malyarinyaya terapiya nevrolynesa i drugikh zabolevaniy nervnoy sistemy, 876
Malmberg, C., Diet and Die, 1945
Malmstead, L., Awaken Your Sleeping Beauty, 243
Maloy, B. S., Nervous and Mental Diseases, 409
Manson-Bahr, P. H., Tropical Diseases, 491
Margarines, Vitamin A Content, 321
Marinesco, G., Des réflexes conditionnels, 70
Marshall, C., Introduction to Human Anatomy, 409
Martin, E. K., comp., Atlas of Pathological Anatomy, 409
Massachusetts Pneumonia Study, 2258
Mateer, F., Glands and Efficient Behavior, 877
Maternal Mortality, Der Geburstod, 565
Maxwell, I., Clinical Bio-Chemistry, 242
Mayo Clinic, 2187
Meat, You Must Eat Meat, 1944
Medical Jurisprudence, Forensic Medicine, 150
Medical Jurisprudence, Treatise, 319
Medical Research Council, Medical Uses of Radium, 1032
Medical Social Work, 1119
Medicine, Basis for Theory of, 1034
Medicine for Nurses, 651
Medicine, history, How the President, Thomas Jefferson, and Doctor Benjamin Waterhouse Established Vaccination, 2259
Medicine, History of Canadian Medical Association, 1867-1921, 2028
Medicine, history, Opuscula selecta Neerlandicorum de arte medica, 1944
Medicine, International Medical Annual, 492
Medicine-Man of the American Indian, 70
Medicine, Osnovy i dostizheniya sovremennoy meditsiny, 1120
Medicine, Practitioners Library, 1943
Medicine, Principles and Practice, 566
Medicine, Sociological, Health and Human Progress, 1415
Medicine, State, Complete Handbook, 1336
Medicine, Text-Book for Nurses, 1517
Medicolegal Examination of Stains, 1845
Men and Women: World Journey of a Sexologist, 321
Mental Disease, Die Seelenstörungen der Blutdruckkranken, 949
Mental Disease, Grundzüge der praktischen Seelenheilkunde, 321
Mental Disease, Nervous and Mental Disease, 409
Mental Disease, Probability of Commitment, 1596
Mental Disorders, Chronic Nasal Sinusitis Relation to, 241
Mental Disorders, Destiny and Disease in, 948
Mental Hygiene, Personality Maladjustments, 151
Merillat, L. A., Veterinary Military History, 1942
Metabolism, Diagnosis and Treatment of Disorders, 152
Microchemistry, Mikroskopische Methoden in der Mikrochemie, 948
Mikulicz-Radecki, F., Die Praxis der Sterilisierungsoperationen, 1035
Military History, Veterinary, 1942
Milk, Bacteriological Grading, 1844
Millis, E. R., What Everyone Should Know About Venereal Disease, 949
Mills, G. P., Text-Book of Surgery for Dental Students, 1119
Miniovich, P. A., Malyarinyaya terapiya nevrolynesa i drugikh zabolevaniy nervnoy sistemy, 876
Mitchiner, P. H., Modern Treatment of Burns and Scalds, 1227
Moersch, F. P., Neurology and Psychiatry for Nurses, 2098
Moore, C. U., Nutrition of Mother and Child, 321
Morgulis, B. I., Anomalii rosta i razvitiya, 1227
Morton, D. J., Human Foot, 1516
Morton, R. A., Application of Absorption Spectra to Vitamins and Hormones, 1517
Mosenthal, H. O., Diagnosis and Treatment of Variations in Blood Pressure and Nephritis, 241
Mother and Baby Care in Pictures, 409
Motion Pictures, Association pour la documentation photographique et cinématographique dans les sciences, 1335
Mouth, La pratique stomatologique, 1417
Movements, Autistic Gestures, 2096
Müller, M., Prognose und Therapie der Geisteskrankheiten, 2098
Mustard, H. S., Introduction to Public Health, 491
Mycology, Medical, 2027
Myotonia, Sammlung psychiatrischer und neurologischer Einzeldarstellungen, 150
Narcotic Addict, Square Deal for, 1843
National Conference of Social Work, Proceedings, 1935, 2187
National Formulary, VI, 2184
National Medical Monographs, Management of Colitis (Bargen) 566
Nephritis, Diagnosis and Treatment of Variations in Blood Pressure, 241
Nerves, Gefässerweiternde Stoffe der Gewebe, 1684
Nervous System, Traité de physiologie normale et pathologique, 2029
Neurology, Etudes neurologiques, 1844
Neurology for Nurses, 2098
Neurology, Practitioners Library, 1943
Neurology, Sammlung psychiatrischer und neurologischer Einzeldarstellungen, 492
Neurose: Lebensnot; arztliche Pflicht, 2098
Neurosis, La neurosis obsesiva, 491
Neurosyphilis, Malyarinyaya terapiya nevrolynesa i drugikh zabolevaniy nervnoy sistemy, 876
Noguera, O. F., Semiología radiológica de la aurícula izquierda, 1845
Nose, Diseases, 320
Nurses, Medicine, 651
Nurses, Neurology and Psychiatry, 2098
Nurses, Textbook of Medicine, 1517
Nursing, Art of Ministering to the Sick, 2259
Nursing, Psychiatric, Guide, 2258
Nursing Technique, Textbook, 1759
Nutrition, Child Nutrition on a Low-Priced Diet, 242
Nutrition of Mother and Child, 321
Obesity treatment, Streamline for Health, 243
Obrig, T. E., Modern Ophthalmic Lenses and Optical Glass, 2186
Obstetric Pelvis, 243
Obstetrical Practice (Beck), 648
Obstetrics, Practical Handbook of Midwifery (Haultain) 1120
Obstetrics, Textbook (Irving), 2185
Okkels, H., Lehrbuch der Endokrinologie, 1335
Ophthalmic Lenses, Modern and Optical Glass, 2186
Oppenheimer, B. S., Treatise on Medical Jurisprudence, 319
Oppenheimer, C., Die Fermente und ihre Wirkungen, 947
Orthodontia, Practical, 1033
Orthopedic Surgery, Russell A. Hibbs, Pioneer, 321
Osler, W., Principles and Practice of Medicine, 566
Osteopathic Lesion, 1417
Otology, Recent Advances, 1118
Otorhinolaryngology, Chirurgie de l'oreille, du nez, du pharynx et du larynx, 1845
Otosclerosis, 1683
Pancreas, Diseases: Diagnosis and Treatment, 732
Pancreas, Lésions du pancréas et troubles fonctionnels pancréatiques, 2258

Book Notices—Continued
Paralysis, General, Electropyrexia in, 1226
Parasitology, Clinical, 68
Parasitology, Human, Introduction, 2097
Parathyroids in Health and in Disease, 734
Parsons, T. R., Fundamentals of Biochemistry, 948
Paterson, R. G., Robert Harvey Reed: Sanitary Pioneer in Ohio, 70
Pathological Anatomy, Atlas, 409
Pathology of Internal Diseases, 151
Pathology, Post Mortems and Morbid Anatomy, 1517
Pathology, Traité de physiologie normale et pathologique, 2029
Pediatric Treatment (Potter) 565
Pediatrics, Diseases of Children (Pfaundler-Schlossmann), 242
Peller, S., Der Geburstod (Mutter und Kind), 565
Pelvis, Obstetric, 243
Perla, D., Spleen and Resistance, 1035
Personality, Anatomy, 1942
Personality and Environment, 1336
Personality Maladjustments and Mental Hygiene, 151
Peterman, M. G., Diseases of Children, 242
Peters, J. P., Body Water, 1033
Peterson, F., Creative Re-Education, 2029
Peterson, L., Beitrag zur Kenntnis des Ileum terminale fixatum und Ileus ilei terminalis fixati, 69
Pfaundler-Schlossmann Diseases of Children, 242
Pharmaceutical Codex, British, 1336
Pharmacology, Handbuch der experimentellen Pharmakologie, 1034
Pharmacopoeia, Extra Pharmacopœia of Martindale and Westcott, 1684
Photography, Association pour la documentation photographique et cinématographique dans les sciences, 1335
Physical Education, Los fundamentos científicos y la práctica de la educación física, 2029
Physical Efficiency and Diet, 875
Physical Therapy, Electrotherapy and Light Therapy, 492
Physicians, Doctor's Odyssey, 1943
Physicians, Doctor of the North Country, 2097
Physicians, For and Against Doctors: Anthology, 1944
Physicians, Medical Man and the Witch During the Renaissance, 732
Physics, Précis de physique médicale, 1944
Physiological Chemistry, Essentials, 243
Physiology, Fundamentals of Biochemistry in Relation to, 948
Physiology, Traité de physiologie normale et pathologique, 2029
Pickworth, F. A., Chronic Nasal Sinusitis and Relation to Mental Disorder, 241
Pittard, E., La castration chez l'homme, 493
Plimmer, V. G., Food Values at a Glance, 1120
Ploss, H. H., Woman, 733
Plum, N., Modification of Virulence of Tubercle Bacilli, 2095
Pneumonia, Epidemiology on Witwatersrand Goldfields, 733
Pneumonia, Lobar Pneumonia and Serum Therapy, 2258
Poinso, R., La diphtérie maligne, 409
Pollen Grains, 1118
Ponroy, Restauration et prothèse maxillo-faciales, 651
Popoff's Quantitative Analysis, 1035
Poteat, W. L., Stop-Light, 734
Potter, P. S., Pediatric Treatment, 565
Practitioners Library of Medicine and Surgery, 1943
Pregnancy, Maladies des femmes enceintes, 1596
Pregnancy, Mother and Baby Care in Pictures, 409
Prescription Writing and Formulary, 948
Prescriptions, Incompatibility: How to Avoid It, 243
Preventive Medicine, Principles and Practice, 2187
Prohibition, Stop-Light, 734
Pryor, H. B., Width-Weight Tables, 2029
Psaume, Restauration et prothèse maxillo-faciales, 651
Psychiatric Nursing, Guide, 2258
Psychiatry, Aus der Werkstatt, 567
Psychiatry for Nurses, 2098
Psychiatry, Nervous and Mental Diseases, 409
Psychiatry, Practical and Clinical Psychiatry, 1034
Psychiatry, Practitioners Library, 1943
Psychiatry, Sammlung psychiatrischer und neurologischer Einzeldarstellungen, 492
Psychiatry, Single Woman and Her Emotional Problems, 649
Psychiatry, Twentieth Century, 2187
Psycho-Analysis for Teachers and Parents, 1758
Psychoanalysis, La neurosis obsesiva, 491
Psychoanalytic Studies, Roots of Crime, 241
Psychodietetics, Classified Bibliography, 71
Psychology, Autistic Gestures, 2096
Psychology, Comparative Psychology, 408
Psychology, Geopsyche, 2258
Psychology, Manuali pratici di medicina biopsicologica, 408
Psychology of Sex (Ellis), 2098
Psychology, Vom Sinn der Sinne, 1943
Psychopathology, Essentials, 2098
Psychopathology, Outlines, 651
Psychosis, Prognose und Therapie der Geisteskrankheiten, 2098
Puerperal Fever, Source of Infection, 1683
Rabies, New Principles of Anti-Rabic Treatment and Rabies Statistics, 1759
Radio, Phenomena of Life: Radio-Electric Interpretation, 1226
Radiology of Bones and Joints, 242
Radium, Medical Uses, 1032
Radium Treatment of Skin Diseases, 649
Rat, Anatomy of, 1844
Ravina, A., L'année thérapeutique: médications et procédés nouveaux, 1759
Rawling, L. B., Head Injuries, 946
Reed, Robert Harvey, A Sanitary Pioneer in Ohio, 70
Réflexes conditionnels, 70
Reichel, H., Blutkörperchensenkung, 2186
Reticulo-Endothelial System, Spleen and Resistance, 1035
Rettger, L. F., Lactobacillus Acidophilus, 648
Reynberga, S. A., editor, Voprosy obshchey i chastnoy rentgenologii, 1227
Rheumatism, Chronic, Causation and Treatment, 1843
Rheumatism, Chronic Streptococcal Toxemia and, 1118
Rice, M. J., Popoff's Quantitative Analysis, 1035
Rice, T. B., Textbook of Bacteriology, 491
Rivoire, R., Les acquisitions nouvelles de l'endocrinologie, 152
Roberts, F., Principles and Practice of X-Ray Therapy, 1226
Roentgenology, Allgemeine Röntgenkunde, 1684
Röntgenology: Borderlands of the Normal and Early Pathological in Skiagram, 1596
Roentgenology, Principles and Practice of X-Ray Therapy, 1226
Roentgenology, Semiología radiológica de la auricula izquierda, 1845
Roentgenology, Textbook, Roentgen Ray in Diagnosis and Treatment, 2186
Roentgenology, Voprosy obshchey i chastnoy rentgenologii, 1227
Roger, G. H., Traité de physiologie normale et pathologique, 2029
Rohrbach, R., Die Hautkrankheiten, 1758
Rose, M. S., Child Nutrition on a Low-Priced Diet, 242
Roxburgh, A. C., Common Skin Diseases, 1417
Russell, H. B., Essentials of Cardiography, 949
Rydin, H., Über Gewebsoxydation bei B_1-Avitaminose und Inanition, 1335
Sabrazès, J., Angines lympho-monocytaires, agranulocytoses, leucémies leucopéniques, 409
Salmon Lecture, Twentieth Century Psychiatry, 2187
Salmonella, Bacteriology, 876
Samuels, S. S., Diagnosis and Treatment of Diseases of the Peripheral Arteries, 1757
Sand, R., Health and Human Progress, 1415
Sanity First, 491
Santamaria, S., Teoria de los neoplasmas, 1759
Savill, A., Hair and Scalp, 1944
Scalp, Hair and Scalp, 1944
Schall, H., Nahrungsmitteltabelle zur Aufstellung und Berechnung von Diätverordnungen, 1945
Schleich, C. L., Those Were Good Days! 2260
Schliephake, E., Short Wave Therapy, 320
Schlink, F. J., Eat, Drink and Be Wary, 650
Schneider, K., Pathopsychologie der Gefühle und Triebe, 2029
School, Delinquent Boy and the Correctional School, 150
Schoolboy, Social Problems of High School Boy, 651
Schoolboy: Study of His Nutrition, Physical Development and Health, 242
Schrumpf-Pierron, P., Thérapeutique cardio-vasculaire, 1685
Schteingart, M., Alimentación y dietética, 2259
Schultz, J. H., Neurose; Lebensnot; ärztliche Pflicht, 2098
Science, Outposts of Science, 2030
Sclerosis, Multiple Sklerose und Tuberkulose, 152
Sears, W. G., Medicine for Nurses, 651
Sensations, Les astéréognosies, 732
Seth, G., Speech in Childhood, 151
Sex, Studies in Psychology of Sex, 2098
Sheldon, J. H., Haemochromatosis, 1684
Shelley, H. M., Epitome of Laboratory Diagnosis and Treatment of Tropical Diseases, 2259
Shelling, D. H., Parathyroids, 734
Shennan, T., Post Mortems and Morbid Anatomy, 1517
Sherman, H. C., Food and Health, 2029
Sherwood, N. P., Immunology, 152
Short, A. R., International Medical Annual, 492
Singer, E., Fasciae of the Human Body, 949
Sinusitis, Chronic Nasal Sinusitis, 241
Skin Diseases, Common (Roxburgh), 1417
Skin Diseases, Die Hautkrankheiten, 1758
Skin, Diseases, (Knowles), 1120
Skin Diseases, Radium Treatment, 649
Skin, Haarkrankheiten und kosmetische Hautleiden, 1033
Slemons, J. M., John Whitridge Williams, 320
Smallpox, How the President, Thomas Jefferson, and Doctor Benjamin Waterhouse Established Vaccination, 2259
Social Problems of High School Boy, 651
Social Work, Medical, 1119
Social Work, Proceedings of the National Conference of, 2187
Solomon, C., Prescription Writing, 948
Spectrum Analysis, Clinical and Pathological Applications, 1035
Speech, For Stutterers, 1597
Speech in Childhood: Its Development and Disorders, 151
Speed, K., Text-Book of Fractures and Dislocations, 241
Speransky, A. D., Basis for the Theory of Medicine, 1034
Spleen and Resistance, 1035
Stafford, G. T., Individual Exercises, 321
Stains, Type Determination in Medicolegal Examination, 1845
Stein, R. O., Haarkrankheiten und kosmetische Hautleiden, 1033
Stephenson, T., Incompatibility in Prescriptions and How to Avoid It, 243
Sterilization, Sexual, Die Praxis der Sterilisierungsoperationen, 1035
Stevenson, R. S., Recent Advances in Laryngology and Otology, 1118
Stoeckel, W., Lehrbuch der Gynäkologie, 876
Stomatology, La pratique stomatologique, 1417
Stomatology, Restauration et prothèse maxillo-faciales, 651
Stop-Light, 734
Storey, T. A., Principles of Hygiene, 2097
Straus, E., Vom Sinn der Sinne, 1943
Strecker, E. A., Practical Clinical Psychiatry, 1034
Streptococcal Toxemia, Chronic, and Rheumatism, 1118
Streptococcus, hemolytic, Source of Infection in Puerperal Fever, 1683
Strömgren, H. L., Die Zahnheilkunde im achtzehnten Jahrhundert, 1119
Stroganoff, B., Traitement de l'éclampsie, 242
Strohl, A., Précis de physique médicale, 1944
Surgery, Chirurgie de l'oreille, du nez, du pharynx et du larynx, 1845
Surgery, Clinical, Demonstrations of Physical Signs, 567
Surgery, Der chirurgische Operationssaal, 70
Surgery, Données Anatomiques en vue de la chirurgie réparatrice mammaire, 1336
Surgery, Introduction à la chirurgie thoracique, 321
Surgery, Practitioners Library, 1943
Surgery: Queen of the Arts and Other Papers and Addresses, 1845
Surgery, Russell A. Hibbs, Pioneer in Orthopedic Surgery, 321
Surgery, Terminology of Operations of University of Chicago Clinics, 409
Surgery, Textbook (Christopher's), 2097
Surgery, Text-Book for Dental Students, 1119
Surgery, Traité de chirurgie d'urgence, 1416
Sutherland, H., Tuberculin Handbook, 2185
Syphilis, Bibliography of Poem Syphilis Sive Morbus Gallicus by Girolamo Fracastoro of Verona, 68
Teeth, La pratique stomatologique, 1417
Terminology of Operations of University of Chicago Clinics, 409
Thenon, J., La neurosis obsesiva, 491
Therapeutics, Handbook of Therapy, 243
Therapeutics, L'année thérapeutique, 1759
Therapeutics, Modern Treatment in General Practice, 1034
Therapeutics, Special Procedures, 409
Thérapeutique cardiovasculaire, 1685
Thérapeutique médicale, 2185
Therkelsen, F., Typebestemmelse ved retsmedicinske pletundersøgelser, 1845
Thomen, A. A., Don't Believe It! Says the Doctor, 2029
Thoms, H., Obstetric Pelvis, 243
Thoracic surgery, Introduction à la chirurgie thoracique, 321
Those Were Good Days! 2260
Throat, Diseases, 320
Tidy, H. L., editor, International Medical Annual, 492
Tissue oxidation, Über Gewebsoxydation bei B_1-Avitaminose und Inanition, 1335
Tonsils, diseases, Radium Treatment, 649
Touch, astéréognosies, 732
Troisier, J., Etudes expérimentales récentes sur les maladies infectieuses, 2187
Tropical Disease, Epitome of Laboratory Diagnosis and Treatment, 2259
Tropical Disease, Geography of Disease, 1517
Tropical Diseases, Manson's, 491
Tropical Medicine, Clinical Parasitology and, 68
Tropical Medicine, Clinical Text-Book, 1942
Tubercle Bacilli, Modification of Virulence, 2095
Tuberculin Handbook, 2185
Tuberculosis, Diagnosis and Treatment of Pulmonary Tuberculosis, 2095
Tuberculosis, Multiple Sklerose und Tuberkulose, 152
Tuberculosis, Tuberculose ostéo-articulaire, 947
Tumors of Urinary Bladder, 1417
Typhoid, Bacteriology, and Carrier States, 876
University of Chicago Clinics, Terminology of Operations, 409

Book Notices—Continued
University of Michigan, Diet Manual of University Hospital, 2259
University of Michigan, Formulary of University Hospital, 1596
Ureters, La litiasis reno-ureteral bilateral, 2259
Urinary Tract, Infections, 243
Van Stockum, M. J., New Principles of Anti-Rabic Treatment, 1759
Venereal Disease, What Everyone Should Know, 949
Veterinary Military History of the United States, 1942
Victor, Sister M., Diet Manual, St. Mary's Hospital, 877
Vignes, H., Maladies des femmes enceintes, 1596
Vitality: A Book on the Health of Women and Children, 321
Vitamin A Content of Sour Cream Butter, Sweet Cream Butter, and Margarines, 321
Vitamin B_1, Über Gewebsoxydation bei B_1-Avitaminose und Inanition, 1335
Vitamins, Application of Absorption Spectra, 1517
Wagner, O., Experimentelle Untersuchungen über Amöbenruhr, 650
Wakeley, C. P. G., Modern Treatment in General Practice, 1034
Walch, J. W., Complete Handbook on State Medicine, 1336
Wallin, J. E. W., Personality Maladjustments and Mental Hygiene, 151
Warden, C. J., Comparative Psychology, 408
Water, Body Water: Exchange of Fluids in Man, 1033
Wayward Youth, 70
Weber, F. P., Endocrine Tumours, and Other Essays, 2259
Weese, H., Digitalis, 1595
Weiss, S., Diseases of the Liver, Gall Bladder, Ducts and Pancreas, 732
Weissenberg, E., Foundations of Short Wave Therapy, 2028
Weisz, H., Die physikalischen und technischen Grundlagen der Hochfrequenzbehandlung, 320
White, W. A., Twentieth Century Psychiatry, 2187
Whitehouse, H. B., editor, Gynaecology, 2186
Whitney, H. A. K., Formulary of the University Hospital, 1596
Wilder, L., Mayo Clinic, 2187
Williams, F. H., Radium Treatment of Skin Diseases, New Growths, Diseases of Eyes, and Tonsils, 649
Williams, J. F., Atlas of Human Anatomy, 1227
Williams, John Whitridge, Academic Aspects and Bibliography, 320
Wilson, G. S., Bacteriological Grading of Milk, 1844
Witch, During the Renaissance, 732
Wodehouse, R. P., Pollen Grains, 1118
Wolf, H. F., Short Wave Therapy and General Electro-Therapy, 2028
Woman: Historical Gynaecological and Anthropological Compendium, 733
Woman, Single Woman and Her Emotional Problems, 649
Zabriskie, L., Mother and Baby Care in Pictures, 409
Zilboorg, G., Medical Man and the Witch During the Renaissance, 732

C

C.C.C.: See Civilian Conservation Corps
CABOT, HUGH, "full steam" or caution in social security, 1737—E
CACHEXIA: See Pituitary
CACODYLATE: See Sodium
CADAVER blood, transfusion of, [Yudin] ★997
CAFFEINE: See Coffee
CAISSON DISEASE, relation to tissue saturation with nitrogen, [Shilling] 163—ab
CALCIFICATION: See also Calcinosis; Lymphatic System; Myositis
changes, 392
mechanism, rôle of phosphate ions in, 384—E
CALCINOSIS, cutaneous, [Costello] 498—ab
universal, [Ramsdell] 254—ab
CALCIUM, additive effect to digitalis; 2 deaths, [Bower & Mengle] ★1151
chloride 10% Ampoule (Lakeside), 1008
Chloride Treatment: See Gallbladder inflammation
concretions (spherical) in epididymis, [Marsella] 1047—ab
cyanamide in fertilizer, poisoning, rôle of alcohol, 237
deficiency disease in adult, [Haden] ★261
Gluconate, Ampule Compound Solution U. S. S. P. Co., 1661
gluconate, induced hypercalcemia, [Lowenburg & Ginsburg] ★1779
gluconate injections, effect on heart, [Berliner] 654—ab
in Blood: See Blood
in diet, effect on hypoparathyroidism, [Cazzamali] 883—ab
in diet, relation to phosphorus, 2161—E
in diet; requirement of human adult, 2213—ab
iodobehenate (Calioben or Sajodin), 239
metabolism and parathyroid surgery, [Mandl] 581—ab
CALCIUM—Continued
metabolism, influence of adrenals, [Schour] 1690—ab
phosphate-phenobarbital sedative, calcium with phenobarbital, [Robinson] 419—ab
Quinine Treatment: See Pneumonia
Treatment: See Bones, cancer; Colitis, ulcerative; Gallbladder inflammation
CALCULI: See Biliary Tract; Gallbladder; Kidney; Urinary Tract
CALIFORNIA MEDICAL ASSOCIATION, resolution on diagnostic medical service, 1168
Ross-Loos case, 300
CALIOBEN: See Calcium iodobehenate
CALORIES, 2,000 needed per day, 1448—ab
CAMPHOR in 0.1 injection, eleomas and lipoid necrosis after, [Repetto] 2203—ab
renohepatic degeneration from, 1750
CAMPS, diets for boys in, 2254
Work: See Work camps
CANADIAN Medical Association, (Alberta Division) 133; (invitation to A. M. A.) 1819, 1907; 1918; (Dr. Routley's address) 1907; (meeting) 1929
CANCER: See also Adenocarcinoma; Chorionepithelioma; Epithelioma; Tumors, malignant: under specific organs as Breast; Uterus; etc.; under Medicolegal Abstracts at end of letter M
Brazilian Congress of (first), 311; 1583
carcinogenic hydrocarbons, viscera tumors induced with, [Ilfeld] 2101—ab
Cells: See Lung cancer
clinics, Baltimore, 544
committee formed, Indiana, 1926
control program, (Kansas) 712; (Maine) 1576
diagnosis, Aron's adrenal cortex reaction, 1019
diagnosis, Botelho's seroreaction, 1583
diagnosis, group examinations, Germany, 638
diagnosis, Kauffmann's inflammatory reaction, [Ebhardt] 1135—ab
diagnosis, Schridde's cancer hair, [Frick] 1048—ab
diet and, 1902—E
etiology, estrogenic substance, 1093—E; [Cramer] 1768—ab
etiology, ultraviolet rays rôle in, [Roffo] 2111—ab
etiology, von Brehmer's Siphonospora polymorpha, 394
Experimental: See Epithelioma
features, Lister Memorial Lecture by Muir, 2079
heredity and, [Little] ★2234
hospital, three million dollars for, New York, 1741
Imperial Cancer Research Fund, report, 716
in child aged 5 (of liver), 135
in slaughtered animals, 935
incidence in gastro-intestinal polyps, [Lawrence] 1420—ab
Koch Cancer Foundation loses malpractice suit, 929
metabolism rôle in, [Beard] 332—ab
metastases, preventing, by postoperative roentgen therapy, 1594
metastases to bone, blood picture in, [Heck] ★1975; [Heymann] ★2050
metastases to bone from breast, large doses of calcium in, [Brunschwig] 737—ab
metastases to bone from stomach, [Kerr] 249—ab
metastases to inguinal gland from penis, [Barringer] ★21
metastasis in lung cancer, [Arkin & Wagner] ★588
mortality, (Hungary) 1023; (increase, California) 2011
Pain in: See also Uterus cancer
pain in, cobra toxin for, [Nekula] 1239—ab
patients (impoverished), financial aid for, 1404
phobia, glossodynia, [Gilpin] ★1722
"Research Aid Fund" of Mavlar Greenfield, 864
scirrhous, diphtherial infection, [Marshall] 2108—ab
Serodiagnosis: See Cancer, diagnosis
survey (Connecticut) 47; (Michigan) 130; (Illinois) 387
Treatment, Radium: See Rectum, cancer; Tonsils, cancer; Uterus, cancer
Treatment, Roentgen: See also Respiratory Tract cancer
treatment, roentgen (unfiltered), [Widmann] 330—ab; [Merritt] 2031—ab
treatment, short wave sensitization, [Fuchs] 2115—ab
trichinosis and, [Schmidt-Lange] 1433—ab
tuberculin reaction in, [Holmgren] 1434—ab
tuberculosis and, in alimentary canal, [Säfwenberg] 968—ab
tuberculosis and, of bronchus, [Fleischner] 1861—ab
virus, 717
CANDLE Jar Method: See Carbon Dioxide
CANDY: See also Chocolate
child's diet and, 1971—ab
CANKER Sores: See Stomatitis
CANNED Food: See Food
Milk: See Milk
CAPILLARIES, Blood Pressure: See Blood Pressure
breakdown, 148
resistance tests; vitamin C deficiency related to rheumatic fever, [Rinehart] 157—ab
CAR: See Automobiles
Sickness: See Train sickness
CARBARSONE, toxicity, [Epstein] ★769
CARBOHYDRATES: See also Dextrose; Lactose; Sugar; etc.
diet (high) in chronic atrophic arthritis, [Bowen] 1233—ab
metabolism, effects of ingesting sodium and potassium salts, [McQuarrie] 1043—ab
metabolism in pneumonia, [Sinelnikov] 259—ab
CARBOLIC ACID: See Phenol
CARBON: See also Charcoal (cross reference)
Arc: See Ultraviolet Rays
intravenously, granulotherapy, [Lumière] 256—ab
Therapy: See Erysipelas
CARBON BISULFIDE poisoning, precautions against, 933
CARBON DIOXIDE, Absorption Technic: See Anesthesia
mephitibiosis, [Nye & Lamb] ★1075
Oxygen Inhalation: See Alcoholism
preservative of cod liver oil, Council statement, 1733
preservative of fish, 470—E
snow treatment of angioma and hemangioma, 561
CARBON MONOXIDE poisoning, headache in garage workers, 1332
poisoning, nervous and mental sequelae, [Shillito & others] ★669
CARBON TETRACHLORIDE, cirrhosis relation to liver regeneration, [Cameron] 1427—ab
poisoning, danger in removing adhesive tape, 1755
poisoning, fatal inhalation of cleaning fluid, [Gonzales] ★286
poisoning hazard in gasoline station attendant, 1409
CARBONIC ANHYDRASE in Blood: See Blood
CARBUNCLE: See Kidney
CARCINOGENIC Hydrocarbons: See Cancer
CARCINOMA: See Cancer
CARDIA: See under Stomach
CARDIODIAPHRAGMATIC Angina: See Angina Pectoris
CARDIOID Condenser: See Microscopy
CARDIOLOGY: See Heart disease
CARDIOSPASM: See Stomach
CARDIOVASCULAR DISEASE, syphilis and, [Weber] 744—ab
syphilis, results of treatment, [Padget] 569—ab
treatment by motorized oscillating bed, [Sanders] ★916
CARDIOVASCULAR SYSTEM status in thyrotoxicosis, [Maher & Sittler] ★1546
CARIES: See Spine
CARLSON, ANTON J., bust unveiled, 2074
CARNATION Company (Year Book of Menus and Recipes), 1009; (Cook Book) 1473; ("Simplified Infant Feeding") 1474
CAROTENE, absorption, [Heymann] 1419—ab
effect on diabetes mellitus, [Ralli & others] ★1975; [Heymann] ★2050
CARPENTER, L. A., illegal practitioner, 2077
CARRIERS: See Gonorrhea; Trichomonas; Typhoid
CARROTS, Cellu Brand, 1735
CARS: See Automobiles
CARTILAGE: See Meniscus; Rib
CASE HISTORY taking in allergic diseases, [Rackemann] ★976
CASEIN, allergy to, treatment, [Schloss & Anderson] 1025—C
production, industrial uses, 710—E
CASTELLANI, ALDO, in military service in Africa, 936
CASTLE'S Factors: See Anemia, Pernicious
CASTOR OIL, place in diet, [McClendon] 64—C
used as laxative even in late pregnancy, 1591
used for hair dressing in asthmatic child, 1839
CASTRATION, self-performed, [Frost & Guy] ★1708
unilateral, by x-rays, [Momigliano] 748—ab
voluntary, Germany, 2018
CATALASE, oxidizing ferments of raw vegetables and digestion, [Matvieeff] 1134—ab
Reaction: See Feces
CATALOGUE: See Index Catalogue
CATAPLEXY, post-traumatic, [Hall & LeRoy] ★431
CATARACT etiology, electric discharge, 66
extraction, frequency of retina detachment after, 1411
produced in rat by lactose or galactose, [Yudkin] 496—ab
CATARRH: See Sinuses, Nasal
CATATONIA: See Dementia Praecox
CATGUT Sutures: See Sutures
CATHARTICS: See Castor Oil
CATHETER, Pezzar: See Empyema
CATTLE: See also Abortion, contagious
freemartin and intersexuality, 1333
Tuberculosis in: See Tuberculosis, avian; Tuberculosis, bovine
CAUDA EQUINA, compression by ligamentum flavum [Abbott] ★2129
level of termination of spinal cord, [Needles] 496—ab
Neuritis: See Neuritis
syndrome after subarachnoid alcohol injection, [Tureen & Gitt] ★1535
CAULIFLOWER, Cellu Brand, 1661

CECUM cancer, diagnostic criteria, [Rosser] ★109
CELLS: See also Cytology
cytoplasmic inclusion bodies in throat, [Broadhurst] 1950—ab
measurement of nuclei in tumors, [Schairer] 425—ab
CELLU (strawberries) 43; (red raspberries) 123; (black raspberries) 215; (prune plums) 467; (pineapple juice) 539; (spinach) 617; (tomatoes) 707; (mushrooms) 782; (yellow string beans) 923; (little kernel corn) 1166; (vegetable combination) 1387; (tips of asparagus) 1473; (green stringless beans) 1474; (tiny beets) 1565; (cauliflower) 1661; (carrots) 1735; (peas) 1809; (rhubarb) 1987
CELLULOSE and hemicellulose, rôle in laxation, [Williams] 412—ab
CEMENT, occupational hazards, 2255
CENTRAL Society for Clinical Research, abstract of proceedings, 245; 324; 412
States Society of Industrial Medicine and Surgery, 544
CEREAL, 1776 Gerolium Breakfast, 1565
CEREBROSPINAL FLUID, bromide in, after taking Peacock's Bromides, [Craven & Lancaster] ★1383
cell count, globulin, colloidal gold and pressure, in syphilis, 2090
cell count in meningitis, 1756
changes in diagnosis of paralysis agitans, 645
drainage in streptococcic meningitis, [Marick] ★2238
in barbituric acid poisoning, 1215
infectivity in lymphogranuloma inguinale, [von Haam & d'Aunoy] ★1642
Pressure: See also Intracranial Pressure
pressure, effect of ergotamine tartrate, [Pool] 954—ab
pressure, effects of hypertonic sucrose solution, [Murphy & others] 245—ab
test for infantile paralysis, 2254
CEREBROSPINAL MENINGITIS: See Meningitis
CEREBROSPINAL SYPHILIS: See Neurosyphilis
CERVICAL Canal: See Uterus
CERVICITIS: See Uterus
CESAREAN SECTION, incidence, [Kosmak] 2089—C
mortality and morbidity, [Arnot] 1340—ab
postmortem, lawful authorization, [Woodward] ★37
pregnancy after sloughing of sutures, [Fist] 1331—C
CEVITAMIC Acid: See Acid
CHAMBERLAIN'S Cough Remedy, 143—BI
CHANCRE, tuberculous, transmitted by kissing, [Sulzberger] 314—C
CHANCROID antigen; dmelcos vaccine, 404
CHARCOAL: See Erysipelas, treatment
CHARLATANISM: See Quackery
CHEDIAK'S Dry Blood Method: See Syphilis, serodiagnosis
CHENO Restorex Tablets, 144—BI
CHEPLIN'S Sodium Cacodylate, 1387
CHERRY, syrup of, formula for, 404
CHEST: See Thorax
CHESTO, 1111—BI
CHICAGO Hospital Council organized, 928
Psychoanalytic Institute, 1320; 1664—E
CHICHESTER'S Diamond Brand Pills, poisoning by, [Motley & McGehee] ★1163
CHICKENPOX and herpes, 564
CHICKENS: See also Eggs
limber neck in, relation to poliomyelitis, 1027; (reply) [Murray] 1682
sensitivity to eggs, 2181
CHILBLAINS, cold allergy, 559
CHILDBIRTH: See Labor; Medicolegal Abstracts at end of letter M
CHILDREN: See also Adolescence; Infants; Pediatrics; under names of specific diseases as Cancer; Syphilis; Tuberculosis; etc.
behavior, [Casparis] ★2208
Belgian puericulture centers, 2083
Children's Bureau, operation and medical profession, 1915
Children's Fund, annual report, 303
Crippled: See Crippled
Delinquent: See Delinquent
Diet: See Diet
Diseases of: See Pediatrics
handicapped, so-called "filter system" for, 1101
health, program (Indiana) 2074; (Michigan) 2165
Hospital for: See Hospitals
Nail Biting in: See Nails
Nutrition: See Nutrition
preschool, magnesium needs of, [Daniels] 2196—ab
school, classified by handwriting speed factor, [Quinan] 419—ab
school, protection against infection, 228
school (secondary), selection, 1509
vitamin A deficiency in, Iowa, [Jeans & Zentmire] ★996
welfare extended with federal funds, New Mexico, 1576
welfare, International Congress for Juvenile Protection, Belgium, 397; 2083
welfare services under Social Security Act, advisory committees meet, 51; 1826
CHINESE, dietaries, 140
Medical Association, biennial conference of, 1107
Remedies: See Hemeralopia
women, tubal factor in sterility of, [King] 2202—ab
CHINIOFON, impairs liver, [Dyckerhoff] 83—ab
CHIROPRACTIC: See under Medicolegal Abstracts at end of letter M
CHIROPRACTORS, association with cults, Judicial Council report, 1197
CHLORAL: See Eclampsia, treatment
CHLORETHANE, toxicity of hexachlorethane and chlorinated retene, 484
CHLORIDES: See also Calcium; Potassium; Sodium
in Blood: See Blood
metabolism in pneumonia, [Sinelnikov] 259—ab
CHLORINATED Retene: See Retene
CHLORINE gassing, treatment, 1222
respirine, 1111—BI
*tri***CHLOROETHYLENE** in angina pectoris, statement by J. C. Krantz, 485
chronic effects, [Taylor] 2033—ab
intoxication, [Eichert] ★1652
CHLOROFORM-strychnine mixture, accidents in manufacture and sale of, 1745
CHLOROPHYLL and blood regeneration, 925—E
vitamin C and, 1315—E
*di***CHLOROPROPANE**, fatal inhalation of cleaning fluid, [Gonzales] ★286
CHLOROSIS; iron therapy, [Patek & Heath] ★1463
CHLORPHENOLATE: See Phenol, tetrachlor sodium
CHOCOLATE Drink: See Beverages
hazard from metal foil on, 1590; [Williams] 2178—C
Hershey's (Milk) 215; (with almonds) 383
Trupak baking: Davis Cooking, 1387
CHOLANGIOGRAPHY: See Bile Ducts, roentgen study
CHOLECYSTITIS: See Gallbladder inflammation
CHOLECYSTOGRAPHY: See Gallbladder roentgen study
CHOLEDOCHOTOMIES: See Gallbladder surgery
CHOLELITHIASIS: See Gallbladder, calculi
CHOLERA, treatment, bacteriophage, [Pasricha] 2109—ab
CHOLERETIC: See Gallbladder
CHOLESTEATOMA, mastoidectomy for, [Shambaugh] 1421—ab
CHOLESTEROL, excess, causes hepatic fatty degeneration, [Beumer] 258—ab
in Bile: See Bile
in Blood: See Blood
metabolism and arterial hyperpressure, [Domenech] 580—ab
metabolism, genesis of gallstones, [Bockus] 2263—ab
metabolism in new-born, [Mühlbock] 581—ab
CHOLINE and fat metabolism, 1201—E
effect of diets low in, [Best] 2111—ab
CHOLINERGIC Fibers: See Nervous System, Sympathetic
CHONDROITIN, Council report, 293
CHORDOTOMY: See Spinal Cord, surgery
CHOREA, Sydenham's, fever therapy (Kettering hypertherm), [Metz] ★1658; [Barnacle & others] ★2046
Sydenham's, magnesium sulfate intramuscularly for [Contreras] 1770—ab
CHORIONEPITHELIOMA, hormonology, [Mandelstamm] 964—ab
CHRISTIAN, HENRY A., anniversary volume, 712
CHROMATOPHOROTROPIC HORMONE, [Jores] 502—ab
CHROMIUM alum hardener, sensitivity to photographic solutions, 1028
plate, industrial hazard in polishing, 1681
toxicity in textile industry, 317
CHROMOSCOPY: See Stomach
CHROMOSOMES in tumors, [Schairer] 425—ab
CHRYSLER Corporation, Industrial Hygiene Laboratories, 545
CHRYSOIDINE, sulfamidohydrochloride: See Erysipelas treatment
CIGAR: See Tobacco
CIGARET Smoking: See Tobacco
CINCHOPHEN, Farastan or Mono-Iodo-Cinchophen, 1411
poisoning; safe method of giving [Palmer] 327—ab
CIRCULATION: See Arteries, coronary; Blood Circulation; Veins
CIRCULATORY Failure: See Heart insufficiency
CIRRHOSIS: See Liver; Lungs; Pleura
CITRATE: See Sodium citrate
CITRIC Acid: See Acid
CIVILIAN Conservation Corps, camps, *Hygeia* in, 1819; 1917
medical service, A. M. A. Committee on Legislative Activities report, 1914
openings for physicians in, 1212
CIVININI, FILIPPO, commemoration, 721
CLAMPS for safe ligature of renal pedicle, [Young] ★1800
CLAMS, polluted, drive against, New Jersey, 49
CLANCY, FRANK J., director of Bureau of Investigation, 861; 1186
CLAUDICATION, intermittent, functional diagnosis, [Kisch] 1613—ab
CLAVICLE, fracture, splint for, [Henry] 1132—ab
fractured, in new-born, [Galloway] ★506
sternoclavicular branchioma, [Fried] 737—ab
CLEANING: See Dry Cleaning
CLEFT Palate: See Palate
CLIMACTERIC: See also Menopause
male, [von Noorden] 2036—ab
CLIMATE, diets in relation to, 139
mountain, therapeutic factor, [Campbell] 2268—ab
Therapy: See Bronchiectasis; Bronchitis; Bronchus infection; Tuberculosis, Pulmonary
CLINIC: See also Cornell Clinic; Venereal Diseases
in Peoria city hall, 471
medical (new) Lausanne, 1749
Parole: See Hospitals, psychiatric
St. Louis clinics, 1015
zone of quiet for, Italy, 1217
CLINICAL Laboratory: See Laboratory
Research, Central Society for, abstract of proceedings, 245; 324; 412
CLITORIS, cancer, ganglionectomy in, [Hausen] 1611—ab
CLOSTRIDIUM: See Bacillus histolyticus
botulinum: See Botulism
CLOTH, Dyes: See Dyes
CLUBBED Fingers: See Fingers
CLUBFOOT: See Foot
COBRA Toxin: See Cancer, pain in
venom causes excitability, [Cicardo] 166—ab
COCCIDIOIDES Granuloma: See Granuloma
COCCUS Infections: See Kidneys
COCCYX, pain in, 67
COD LIVER OIL, concentrate added to Pevely Evaporated Milk, 467
Council statement on (dosage) 1732; (carbon dioxide as preservative) 1733; (malt preparations with) 1735
overdosage, harmful effects, 66
Treatment: See Amputation stumps; Burns; Sinusitis; Ulcers; Wounds
COFFEE, effect on efficiency, [Voigt] 1136—ab
COITUS: See also Fridigity; Impotence; Impregnation, artificial; Libido
aspermia (lack of expulsion of semen), 728
during gonorrheal prostatitis, 403
epilepsy attacks occur after, 486
puerperal infections after, [Koller] 963—ab
twins by different fathers, 730
COLD: See also Milk, frozen
allergy, 559
effect in arterial hypertension, 873
hemoglobinuria (transitory) after exposure [Salén] 260—ab
Pressor Test: See Blood Pressure, reactibility
Therapeutic Use: See Head injuries; Stomach hemorrhage
COLDS, treatment, bacteriophage, [Schreuder] 1522—ab
treatment, mercury or mercurochrome instillations [Bassler] 161—ab
COLITIS, Amebic: See Amebiasis
bacillary dysentery relation to [Felsen] 2191—ab
combined form of ileitis and, [Crohn & Rosenak] ★1; [Rosenblate & others] ★1797
mucous, 1594
treatment, colon bacillus vaccine, [Mateer] 570—ab
ulcerative (chronic), Bacterium necrophorum in, [Dack & others] ★7
ulcerative (chronic), calcium and parathyroid therapy [Haskell] 156—ab
ulcerative (chronic), characteristics of hemolytic B. coli in, [Nicholls] 1338—ab
ulcerative (chronic), pyogenic skin lesions in, [Jankelson] 1847—ab
ulcerative (chronic), surgical treatment, [Kunath] 1126—ab
ulcerative, streptoococcus from, [Torrey] 1041—ab
ulcerative with profuse bleeding, oxygenation in, [Golob] ★1725
COLLAPSE: See Lungs
Therapy: See Tuberculosis, Pulmonary
COLLES' Fracture: See Radius
COLLINS, SELWYN D., use of term "immunization," [Bergey] 483—C
COLON, ascending, hole in mesentery; descending colon passes through dense ring, [Cullen] ★895
cancer, [Devine] 1131—ab
cancer, clinical aspects, [Mirer] 504—ab
cancer, diagnostic criteria, [Rosser] ★109
cancer, surgical treatment, [Koch] 341—ab
involvement in ileitis, [Crohn & Rosenak] ★1; [Rosenblate & others] ★1797
irrigation, [Krusen] ★118; [Bastedo] 642—C
irrigation with pure oxygen in amebiasis, [Golob] ★1725
megacolon (congenital), Hirschsprung's disease, [Adson] ★365; 561
mobile, [Cade] 1607—ab
polyposis, [Hardy] ★910
spastic, and sexual hypersensitiveness, 646
surgery, 2251
COLONIAL Troops: See Army, Italian
COLOR BLINDNESS, testing, with Stilling or Ishihaha colored plates; also anomaloscope, 148

COLORADO Medicine: See Journals
COLPOSCOPY: See Uterus cancer
COLWELL, NATHAN PORTER, death, 231
COMA: See Acidosis; Bromide; Diabetes Mellitus
COMELLI'S SIGN: See Scapula fracture
COMMITTEE: See also American; National
A. M. A. See American Medical Association
for Survey of Research on the Gonococcus and Gonococcic Infections, 1313—E
for the Study of Suicides, 713; 1324
to study silicosis, 1828
COMMONWEALTH Fund: See Foundations
COMMUNICABLE DISEASES: See also Infectious Diseases
in rural population, Illinois, 302
report, Maryland, 472
COMPENSATION of Physicians: See under Medicolegal Abstracts at end of letter M
COMPLEMENT Fixation Test: See Amebiasis; Blastomycosis; Gonorrhea
CONCEPTION: See Impregnation; Superfetation
Control: See Birth Control
CONCRETE: See Cement
CONCUSSION: See Brain; Spinal Cord
CONDENSER, paraboloid or cardioid, for dark field studies, 147
CONDUCTION System: See Heart
CONFERENCE: See also International
of State and Territorial Health Officers, 1323
on laws of warfare, 475
on Psychiatric Education, 474; 2014
CONGO RED: See Hemorrhage, treatment; Uterus hemorrhage
Test: See Amyloidosis
CONGRESS: See also American; International; National
of Alienists and Neurologists of France and French Speaking Countries, 935
of Comparative Pathology (third), 1106
of Dermatology and Syphilology, Italy, 1750
of German Gynecologic Society (fiftieth), 394
of Jewish Physicians, 932
of Radiology (ninth), 392
of Regional Medicine (first), 1583
of Urology (first), 1583
on Medical Education: See American Medical Association
U. S., Medical Bills in: See Legislation
CONJUNCTIVA, rhinosporidiosis, [Karunaratne] 1428—ab
CONJUNCTIVITIS, etiology, sensitivity to yellow mercuric oxide, 404
scarlet fever, [Otto] 584—ab
CONNAUGHT LABORATORIES, western division, 391
CONNECTIVE Tissues: See Tissues
CONSCIOUSNESS, loss of, and hypocalcemia, [Kayser] 1770—ab
CONSTIPATION, chronic, advantages and ill effects of liquid petrolatum, 66
chronic, cause of incontinentia alvi, [Priesel] 1430—ab
functional, management, [Schultz] 497—ab
in children, 726
CONSTITUTION, individual, evaluation, 639
menarche and delivery, [Weysser] 1957—ab
CONSTITUTION, U. S.: See United States
CONTACT Dermatitis: See Dermatitis venenata
CONTAGIOUS DISEASES: See Infectious Diseases
CONTRACEPTION: See Birth Control
CONTRACTS: See under Medicolegal Abstracts at end of letter M
CONTRACTURE of thumb, congenital flexion, [Regele] 1614—ab
Volkmann's ischemic, splint for, [Meyerding] ★1139
CONVALESCENCE: See Surgery
CONVALESCENT Blood: See Measles
Serum: See Spider bite
CONVULSIONS: See also Eclampsia; Epilepsy
diagnostic value in brain tumor, [Sachs] 1854—ab
endocrinology and, [Pigott] 1523—ab
later fate of children with, [Bergemann] 1774—ab
COOK BOOK: See Carnation
COOK COUNTY Hospital: See Hospitals
COOKING: See also Food
utensils, aluminum, 218—E; 1497—E
COOPERATIVE Medical Advertising Bureau: See American Medical Association
COPELAND BILL, 1175; 1179; [Woodward] ★1896; 1902—E
COPPER, effect on hemoglobin formation in normal children, [Ross] 1127—ab
pigmentation of skin and hair and, 629—E; [Alt] 1220—C
Sulfate: See Staphylococcus infections
COPYRIGHT act H. R. 10632, A. M. A. Board of Trustees oppose, 860
COR PULMONALE: See Heart insufficiency
CORBUS-Ferry Filtrate: See Gonococcus; Gonorrhea treatment
CORN, Cellu Brand, 1166
smut as abortifacient, toxic action, [Dragisić] 1430—ab
CORNEA dystrophy, 404
tattooing of eyes, 1116
CORNED Beef: See Beef
CORNELL Clinic, 384—E
CORNS, surgical treatment, [Galland] 658—ab
CORONARY Artery: See Arteries; Thrombosis, coronary
CORONER'S inquest, reform, England, 1018
vs. medical examiner system, Leary] 1408—C
CORPORATIONS: See under Medicolegal Abstracts at end of letter M
CORPORIN, 1808
CORPUS LUTEUM cyst, 2182
cyst, ruptured, massive abdominal hemorrhage from, [Jones] 2264—ab
Hormone: See also Progestin hormone, nomenclature, 1808
hormone therapy, [Neumann] 1136—ab
CORSETS, Spencer Supports, 2149
COSMETICS, Copeland Food, 1175; 1179; [Woodward] ★1896; 1902—E
Elorda Creams, 1678—BI
Formula for Setting Hair: See Hair
law upheld by Federal District Court, Maine, 1209
lip stick dermatitis; methyl heptine carbonate, 470—E; [Landsteiner & Jacobs] 1112—C
theatrical grease paint, lead poisoning from, [Bartleman] 2199—ab
COTTON Dyes: See Dyes
COUGH: See also Hemoptysis; Sputum (cross reference); Whooping Cough
expectorants and expectoration, 135
treatment at Cook County, 16 prescriptions; [Fantus] ★375
COUGHING, indirect fracture of rib from, [Richardson] ★1543
COUNCIL: See under American Medical Association; Tuberculosis
COUNTY Health Unit: See Health
Society: See Societies, Medical
COUSINS, marriage of, dangerous? 1506
COUTARD Method: See Respiratory Tract cancer
COWS: See Abortion, contagious; Cattle; Udders
Tuberculosis in: See Tuberculosis, bovine
CRACKING Noise: See Jaws
CRAGMOR Sanatorium reorganized, 927
CRAMP, ARTHUR J., retirement, 861; (tribute to) 1185; 1918
CRAMPS, muscle, 1679
muscle; crampus neuroses and gout, [Vogl] 1137—ab
CRANIOTOMY, subtemporal and suboccipital myoplastic, [Cone] 655—ab
CRANIUM: See also Fontanels; Head; Oxycephaly
abnormalities, [Thannhauser] ★908
hereditary enlarged parietal foramina, [Pepper] 1038—ab
Pressure in: See Cerebrospinal Fluid; Intracranial Pressure
topography to denote positions of cerebral fissures, [Bértola] 1047—ab
CREAM, Cosmetic: See Cosmetics
preservatives in, 481
CREATINE diagnostic test for male sex hormone disturbances, [Steinach] 1862—ab
CREATININE in Urine: See Urine
CREDIT Bureau: See Economics, Medical
CRETINISM, hypoglycosuria (hypoglycemia) with, thyroid treatment, [Costello] 1604—ab
CRIMINAL behavior in later life, 1567—E
mental status, 1826
CRIPPLED children, department for, established, North Carolina, 2166
children's hospital, New Mexico, WPA funds for constructing, 1101
underwater therapy, 478
CRISIS, Gastric: See Tabes Dorsalis
CROSS, KERR, death, 1406
CRUMMER, LEROY, commemoration, 219
CRYPTOLEUKEMIA, [Emile-Weil] 1341—ab
CRYPTORCHIDISM: See Testis, undescended
CUFF, improved, for Pavaex, [McKelvey] ★920
CULTS: See also Nature cure
physicians associated with, Judicial Council report, 1197
CULTURE: See Bacillus; Bone Marrow
CUMMING, HUGH S., retires, 391; 716; 859—E
CURARINA; alcoholic cure-all, 724—BI
CURRICULUM: See Education, Medical
CYANAMIDE poisoning, rôle of alcohol, 237
CYANATE in Blood: See Blood
CYANIDE: See Ferrocyanide (cross reference)
CYANOSIS, carbonic anhydrase in blood, [Hodgson] 1857—ab
CYCLING: See Bicycles
CYCLOPROPANE: See Anesthesia
CYLINDRURIA: See Urine
CYST: See Bones; Breast; Corpus Luteum; Iris; Kidney; Lungs; Meniscus; Ovary; Ureteritis; etc.
CYSTINE in nails, technic for determination, 943
CYSTOSCOPE: See Bladder
CYTOLOGY: See also Tumors
experimental, fourth International Congress for, 1744

D

D.D. Capsules, 143—BI
DAKIN-WEST Liver Fraction: See Anemia, Pernicious, treatment
DAKOTA Jack's Cowboy Liniment, 558—BI
DAMAGES: See Malpractice; under Medicolegal Abstracts at end of letter M
DARK Adaptation Test: See Vitamin A deficiency
Room: See Ophthalmoscope
DARKNESS, pituitary hormone content and, [Jores] 502—ab
DAVIS Brand Cooking Chocolate, 1387
DAVIS, MICHAEL, "full steam" or caution in social security, 1737—E
DAYLIGHT: See Light
DEAD BODIES: See Cadaver
DEAFNESS: See also Hearing; Otosclerosis
Acousticon, 1007
electrical aids, 54
exploitation, 2016
hardness of hearing, 560
DEATH: See also Embalming; Murder; Suicide; and list of Deaths at end of letter D; Medicolegal Abstracts at end of letter M
cardiac, in coronary thrombosis, [Willius] ★1891; ★1892
cause of, in air embolism, [Pfanner] 2267—ab
from drowning, diagnosis, 1223
Liver: See Liver
of Physicians: See Physicians
right to die (Voluntary Euthanasia Legalization Society) 224; 549; 636
DEBATE: See Medicine, state
DECHOLIN, use in absence of gallbladder, 2026
DECLARATION of Independence, five signers were doctors, 2235—ab
DEFECTS: See also Heart; Mental Defectives; etc.
congenital, in siblings, [Murphy] ★457; [Kleindienst] 502—ab; [Reid] 1221—C
DEFICIENCY DISEASE, multiple specific nutritional, in adult, [Haden] ★261
DeFOREST DYNATHERM, 1270
DEFORMITIES: See Abnormalities; Thorax
DEGENERATION: See Macula Lutea; Meniscus; Muscles
Fatty: See Liver
DEGLUTITION: See Swallowing
DEHYDRATION, pre- and postoperative treatment, [Kirk] 586—ab
DELAWARE State Medical Journal: See Journals
DELINQUENT children, agency to deal with, New York, 1668
heredity of institutional inmates, Germany, 1404
DELIRIUM Tremens: See Alcoholism
DEMENTIA PARALYTICA: See Paralysis, General, of insane
DEMENTIA PRAECOX, adolescent psychoses, 60; 295—E
blood pressure (peripheral venous) in schizophrenic, [Krinsky] 1125—ab
effect of alcohol in catatonic, [Kantorovich] 572—ab
preventing loss of weight in, [Finkelman] 156—ab
problems, [Smith] 1616—ab
research financed by Scottish Rite Masons, 132
treatment, hematoporphyrin, [Angus] 1599—ab
DENGUE-like fever in northern California, [Cheney] 331—ab
DENTAL disease, research on, at Indiana U., 1926
Eastman Dispensary, dedicated, 1744
education, Kansas City, 1277
Plates: See Teeth
Practice Acts: See under Medicolegal Abstracts at end of letter M
service (school), England, 636
DENTIN: See Teeth
DENTISTS, advertising, newspaper bars, 2013
women, Germany, 2082
DENTITION: See Teeth
DEPRESSION, Economic: See Economics
Mental: See Mental Depression
DERMATITIS: See also Eczema; Pruritus; Urticaria; etc.
atopic (adult), specific skin hypersensitivity, [Sulzberger & Goodman] ★1000
atrophic (progressive and diffuse), in leprosy, [Pardo-Castello] 740—ab
Contact: See Dermatitis venenata
exfoliative, from carbarsone, [Epstein] ★769
exfoliative, from "Slim" (dinitrophenol), [Hitch & Schwartz] ★2130
from arsphenamine (experimental), [Cormia] 1601—ab
from lip stick, methyl heptine carbonate, 470—E; [Landsteiner & Jacobs] 1112—C
from paint, 238
from photographic solutions, 1028
from quinine, [Settle] ★1801
from rubber gloves; 730, (reply: steeping hands in boric acid), [Bailly] 1224
from tryparsamide, 726; (reply) [Bragman] 1224; [Cormia] 1224
from wrist watch straps, 1738—E
irritant, and pyodermia, 1223
neonatal, [Carter] 2199—ab
of penis from ephedrine, [Hollander] ★706
of scrotum, persistent, 1938
purpuric pigmented lichenoid, [Michelson] 158—ab
venenata from ragweed, oil desensitization, [Brunsting & Williams] ★1533
venenata or dermatitis herpetiformis? 1115
venenata, prevention by poison ivy extract, [Molitch] 2032—ab
venenata, produced at distance by gasoline, [Biederman] ★2236
X-Ray: See Roentgen Rays
DERMATOLOGY, American Board of, 1498
Congress of, Italy, 1750
Italian society, meeting, 2020

DERMATOLOGY—Continued
Libman-Sacks syndrome relation to, [Belo. 2031—ab
unusual field for those interested in general pathology, 1214
DERMATOMYOSITIS simulating trichiniasis, [Merritt & Rosenbaum] ★1646
DERMATOPHYTOSIS, 560
DERMATOSIS: See Skin disease
DERMOGRAPHISM, 1515
DESENSITIZATION: See Ragweed dermatitis; Tuberculin
complications, arteriosclerosis, 2180
DE SILVIO, RAMON L., sentenced, 2165
DESK, American Universal, 538
DESQUAMATION: See Scarlet Fever
DETOXIFICATION: See Vaccine
DEUTERIUM, desaturation of fatty acids, 1665—E
DEVONSHIRE'S Earth Salts, 143—BI
DEXTROSE, in Urine: See Urine sugar
injection (intravenous), best strength to use? 1682
injection (large volume intravenous), [Cutter] ★1250
N. N. R., 383; 2239
DIABETES, BRONZE: See Hemochromatosis
DIABETES INSIPIDUS, diagnosis; powdered pituitary treatment, [Hanssen] 884—ab
elimination of creatinine and urea in, [Hanssen] 884—ab
treatment, pregnancy urine (Antuitrin-S), [Allen & Stokes] ★780
DIABETES MELLITUS: See also under Medicolegal Abstracts at end of letter M
A. M. A. special exhibit on, Kansas City, 1296
acidosis, cause of abdominal pain in, [Walker] 1850—ab
Berlin Medical Society discuss, 1508
blood in, carotenemia, [Ralli & others] ★1975; [Heymann] ★2050
blood sugar and lactose in milk of women with, [Tolstoi] 78—ab; 469—E
blood sugar curves (daily), [Schöne] 258—ab
blood sugar relation to glycosuria, 307
complications, arteriosclerosis and hypertension, [Root] 1039—ab
complications, coronary thrombosis, [Raab & Rabinowitz] ★1705
complications, gastric ulcer, diet for, [Lampé] 503—ab
complications, pulmonary tuberculosis, [McKean] 324—ab
complications, vascular disease in obese, [Beck] 572—ab
Diet: See Diabetes Mellitus, treatment
effect of estrogenic substance on, [Collens & others] ★678
effect of vitamin A and carotene on, [Ralli & others] ★1975
etiologic relation to amebic dysentery, 2094
etiology, arteriosclerosis, [Beck] 572—ab
etiology, burns, 2256
follow-up study of young patients, 1932
in ex-service men, [Matz] ★2214
in New York City, statistics from Bellevue, [Tiber] ★1537
insulin in, effects of alcohol on, 730
insulin in patients with coronary sclerosis, [Collens] 1849—ab
insulin protamine compound, [Hagedorn & others] ★177; [Root & others] ★180; 217—E; [Sprague & others] ★1701; [Kerr] 2194—ab
insulin resistance in acute prostatic obstruction, [Blaisdell] 1853—ab
insulin-sensitive and insulin-insensitive types, [Himsworth] 1610—ab
liver damage and hyperglycemia, 1592
liver enlargement in, [Hanssen] ★914
nervous system changes in, [Sheppe] 659—ab
neuropathy in, lipids in nerves, [Jordan] 1231—ab
New York Association, report, 1826
pituitary and, [Anselmino] 585—ab; (involvement) [Effkemann] 1862—ab
polyneuritis, 2020; 2180
pregnancy and, [Reznitskaya] 1050—ab; [Kraus] 1955—ab
pregnancy and, offspring well protected against, 136
"silent" periods, 1327
treatment, adrenal denervation, Addison's disease after, [Rogoff] ★279; 294—E; [Hutton & others] 1753—C; (reply) [Rogoff] 1753—C
treatment, Diatone—alleged insulin substitute, 1939
treatment, diet, [MacBryde] 248—ab
treatment, diet, Cellu products, 43; 123; 215; 467; 539; 617; 707; 782; 923; 1166; 1387; 1473; 1474; 1565; 1661; 1735; 1809; 1987
treatment diet, conditioned Stolte's free, [Erckientz] 424—ab
treatment, in patients 58 and 83, 1413
treatment, irradiation, [Hutton] 1040—ab; 1753—C
treatment, manganese, 2182
treatment, pancreotoxin, [Sacharov] 426—ab
treatment, raw or dried pancreas, [Barbera] 964—ab
treatment, sorbose, antiketogenic action, [Grieshaber] 1433—ab
treatment, splanchnic nerve section in place of adrenal denervation, [de Takáts] 871—C
DIABETES MELLITUS—Continued
treatment, William Howard Hay, 63—BI
urine dextrose, potassium ferricyanide test, [Gugliucci] 1860—ab
urine in, essential fructosuria, [Marble & Smith] ★24
DIAGNOSIS: See also under names of specific diseases
History Taking: See Case History
institutes, defined, Germany, 478
medical service, resolution from California Medical Association on, 1168
DIANA Sosborszesz, 1111—BI
DIAPHRAGM, atrophy after phrenicectomy, [Galan] 1525—ab
elevation in pulmonary tuberculosis, 1406
flutter with angina pectoris symptoms, [Porter] ★992
Therapeutic Paralysis (Phrenicectomy): See Nerves; Tuberculosis, Pulmonary
DIARRHEA: See also Dysentery
after using gallbladder dye, 1841
emotion and, [Sullivan] 1423—ab
hyperthyroid, [Richieri] 424—ab; 1342—ab
infectious, anaerobic streptococci in, [Johnston] 497—ab
infectious, epidemic in new-born, [Barenberg & others] ★1256
prevents typhoid from developing, [Robertson] 1232—ab
treatment, colon bacillus vaccine [Mateer] 570—ab
DIASTASE in Blood: See Blood
in Urine: See Urine
DIATHERMY, Aloe Short Wave Diatherm, 122
Comprex Short Wave Unit, 1468
DeForest Dynatherm, 1270
effects on liver cells in pernicious anemia, 1591
Fever: See Paralysis, General
Fischertherm, 1563
Hogan Brevatherm Short Wave, 42; 1660; 2148
Junior Bovie Electro (surgical and medical) Unit, 707
Lepel Machine (Type RFC), 921
McIntosh Junion Metro-Coagulator, 921
medical, [Coulter] ★209
radio interference by short wave—"the shadow," 1094—E
Rose CW Short Wave Diatherm, 43
short wave, [Coulter] ★209
short wave heating of tissues, [Coulter & Carter] ★2063
short wave machines; equipment, Council report, 1007; 1174
short wave sensitization of neoplasms, [Fuchs] 2115—ab
Surgical: See Rectum; Stomach
Treatment: See Fractures; Lungs abscess; Pneumonia; Sciatica; Uterus
Universal Bovie Unit, 1008
DIATONE—alleged insulin substitute, 1939
DICHLOROPROPANE: See Chloropropane
DICK Test: See Scarlet Fever
DIENER, RICHARD, Curarina, 724—BI
DIET: See also Food; Infants, feeding; Nutrition; Vitamin
acid or alkaline, vs. action of gonadotropic hormones, [Bock] 582—ab
Calcium in: See Calcium
cancer and, 1902—E
Carbohydrate: See Carbohydrate
children's, and candy, 1971—ab
children's vitamin content of foods in, [Fellers] 495—ab
Chinese, 140
Choline: See Choline
Diabetic: See Diabetes Mellitus, treatment
for boys in camps, 2254
gastrostomy feeding, [Franseen] ★1373
Hay (William Howard), letter from ex-patient, 63—BI
human, long term experiment with rats on, [Orr] 1132—ab
in relation to cevitamic acid excretion [Chakraborty] 1859—ab
in relation to climate, race and work, 139
in relation to tropical ulcers, 139
Infants: See Infants
modern, deficiencies, 392
of families with low incomes, 1201—E
of the poor, problem, England, 1213
Phosphorus: See Phosphorus
restricted, effect on bones, 55
Salt-Deficient: See Salt
Stoll's Diet-Aid, 1111—BI
Stolte's "Free": See Diabetes Mellitus, treatment
Therapeutic: See Hematemesis; Melena; Obesity; Peptic Ulcer
time of day for heavy meal, 1224
vegetable oils in, [McClendon] 64—C
DIEZ, JULIO, honored, 1510
DIGALEN: See Digitalis
DIGESTION, disorders, albuminuria and cylindruria in, [Rohmer] 256—ab
effect of alcohol on, [Blotner] ★1970
hormone of gallbladder wall with lipolytic activator effect, [Pribram] 168—ab
oxidizing ferments of raw vegetables and, [Matvieeff] 1134—ab
rôle of indigestible food residues in laxation, [Williams] 412—ab
time food remains in stomach, 983—ab
DIGESTIVE TRACT: See Gastro-Intestinal Tract
DIGIFOLINE-Ciba, Ampules, 2150
DIGITALIS, additive effect of calcium and digalen; 2 deaths, [Bower & Mengle] ★1151
glucosides, cumulative action and cardiac necrosis, 541—E
therapy, 150 years, 1748
too much, 1270—ab
DIHYDROXY-ANTHRANOL: See Ringworm
DIIODOTYROSINE: See *di*Iodotyrosine
DILEX-REDUSOLS, 1587—BI
DIMETHYL Carbinol: See Isopropyl Alcohol
DIMINICI, LEONARDO, 1405
DINITROPHENOL: See *di*Nitrophenol
DIODRAST: See Veins, roentgen study
DIPHENYL and diphenyloxide in industry, 65
DIPHTHERIA, antitoxin, commend physician for giving before positive culture, 874
bacilli, bactericidal power, [von Gagyi] 1237—ab
bacilli differentiation and urea, [Püschel] 1772—ab
blood transfusion in, [Seckel] 425—ab
complicating scarlet fever, [Zabin] 1588—C; [Levinsohn] 2253—C
gangrene in, [Glumberger] 1430—ab
immunization (active) of tuberculous children, [Starcke] 1861—ab
immunization campaign, Missouri, 1399
immunization, compulsory, France, 2249
immunization, immediate and vital issues, [Bousfield] 660—ab
immunization of children, age for, 1756
immunization plan for infants and children, 1331
immunization with toxoid activated by aluminum oxide, 1510
infection of scirrhous cancer, [Marshall] 2108—ab
lesions, rare localization, [Eyvin] 1433—ab
malignant, renal impairment in, [Brugsch] 1772—ab
meningitis, (rare), [Carlson & Morgan] ★1164
mortality and insurance physician, Germany, 1674
mortality in large cities of U. S., ★2060
old and new problems in, 1404
prophylaxis, France, 2249
pseudo Schick reaction and toxoid test of Moloney, [Mitman] 1132—ab
record, 10 year, Ohio, 1826
Toxin-Antitoxin Mixture 0.1 L + (Goat), 122
toxin diluted ready for use in peptone buffered diluent for Schick tests, 564
Toxin for the Schick Test, Diluted Ready for Use, 122
toxoid, Alum Precipitated, Refined, 1565
toxoid, no paralysis after, 403
toxoid, use in immunization, 148
DIPLOMA: See Licensure
DIRECTION, sense of, in drivers, 1329
DIRECTORY: See also American Medical Association
commercial, A. M. A. resolution on unethical listing of physicians, 1823; 1921
DIRT: See Dust
DISABILITY after abdominal operation; when can a man return to work, 1841
DISCOVERIES, scientific, and patents, 1388—E
DISEASE: See also Death; Diagnosis; Epidemics; Therapeutics; Vital Statistics; etc.; Medicolegal Abstracts at end of letter M
Carriers: See Gonorrhea; Trichomonas; Typhoid
Communicable: See Communicable Diseases
control problems created by floods, 1092—E
Epidemics: See Epidemics
evolution, 1812—E
first aid for sudden illness, Germany, 1215
geomedical knowledge, 1106
Heredity: See Heredity
Industrial: See Industrial disease
Infectious: See Infectious Disease
localization and homologous arteries, [Wiesner] 1239—ab
Milk-Borne: See Milk
organic, correlation of psychic and somatic disorders, [Fetterman] ★26
Rate: See Vital Statistics, morbidity
DISHES: See Aluminum; Glassware
DISINFECTANTS: See also Bactericides
use in artificial pneumothorax, [Müller] 750—ab
DISLOCATION: See also Elbow; Hip Joint; Knee; Sacro-Iliac Joint; Shoulder
treatment, heat, [Gill] ★41
DISPENSARY: See Dental; Tuberculosis
DISPLACEMENT Method: See Sinusitis
DISSOCIATION: See Tubercle Bacillus
DISTEMPER, inoculate dogs against, 944
DIURESIS, action of acacia in nephrotic edema, [Hartmann] 416—ab
antidiuretic principle of postpituitary extracts, [Heller] 748—ab
how to increase efficacy of diuretics, [Fleckseder] 168—ab
in cardiac edema, [Wood] 1689—ab
mercurial diuretics in cardiac dyspnea, [Levin] 2265—ab
mercurial diuretics, research by George Herrmann et al., [Decherd] 483—C
mercurial (new organic) diuretics, [Pontius] 416—ab
spontaneous, in liver disease, [Jones] 78—ab
DIVERTICULUM: See Intestines; Stomach
DIZZINESS: See Vertigo

DMELCOS vaccine: chancroid antigen, 404
DOCTORS: See Physicians
DODGE, RAYMOND, portrait, 2163
DOGS, blood count and blood chemistry, 402
homeless, and echinococcus, 396
inoculation against distemper, 944
stray, and rabies, 2173
DOLE Brand Hawaiian Pineapple, 707; 923; (spears, gems) 1166
DONATIONS: See Hospitals
DONORS: See Blood Transfusion
DOUCHE, vaginal, bacteriostatic astringent preparation, 1682
DOWICIDES, eruptions in lumber workers, 2092
DOWNING, AUGUSTUS S., death, 713
DRAINAGE: See Cerebrospinal Fluid; Empyema; Pericarditis; Thorax
DRESSINGS, pressure, marine sponge, [Bartlett & Bartlett] ★1386
DROMEDARY Brand, (grapefruit) 43; (grapefruit juice) 215; (orange grapefruit blend) 293; (orange-grapefruit juice) 383
DROPSY: See also Ascites; Edema
congenital, of fetus, [Czyzak] 2116—ab
DROWNING, diagnosis of death from, 1223
DROWSINESS: See Sleep disorders
DRUG STORES: See Pharmacies
DRUGS: See also Pharmacology; Pharmacopeia; under Medicolegal Abstracts at end of letter M
A. M. A. resolution on pure food bill (Copeland), 1173; 1188; 1915; 1918
accidents after medicinal use of, 1745
accidents in manufacture and sale, 1745
action on induced ventricular rhythms, [Nathanson] 324—ab
Addiction: See Morphine
advertising, A. M. A. resolution on, 1922
Copeland Bill, 1175; 1179; [Woodward] ★1896; 1902—E
DRUGS—Continued
labeling of products subject to deterioration, Council report, 1807
nihilism and recent graduate, [David] ★405; (druggist treats everything) [Schwartz] 871—C
price increase, Rumania, 720
radiopaque pills, extraneous shadows complicating urography, [Hartung & Wachowski] ★596
Traffic: See Narcotics
USEFUL DRUGS, report, 1171
warning against public recommendations of medicaments, Germany, 1674
DRY CLEANING fluid, "Quick as a Wink," fatal inhalation, [Gonzales] ★286
DRY ICE: See Carbon Dioxide snow
DU BOIS, EUGENE F., New York Hospital and medical education, 384—E
DUCTLESS GLANDS: See Endocrine Glands
DUFFY'S Anti-Bilious Pills, 143—BI
DUKE Endowment: See Foundations
DUNHAM Foundation: See Foundation
DUODENUM, cancer, diagnostic errors, [von Haberer] 502—ab
cancer, extension from stomach, [Castleman] 1762—ab
cancer, relation to ulcer, [Startz] 745—ab
Ulcer: See Peptic Ulcer
DURET Hemorrhage: See Brain
DURKEE'S Brand Oleomargarine, 1809; 1899
DUST: See also Pneumoconiosis
combating, methods employed, 1676
odor of heated house dust effect on appetite, [Winslow] 952—ab
DUTY: See Tax
DWARFISM, biologic effects of pineal extract (Hanson), [Rowntree & others] ★370
renal rickets and, [Chown] 1608—ab
DYES: See also Amido Azotoluene; Congo Red (cross reference); Gentian Violet (cross reference); Neutral Red; Medicolegal Abstracts at end of letter M
cotton, and polyneuritis, 237
cotton, toxicity, in textile industry, 317
Therapy: See Hemorrhage; Leprosy; Uterus hemorrhage
toxicity in hosiery industry, 729
DYNATHERM, DeForest, 1270
DYSENTERY: See also Diarrhea
Amebic: See Amebiasis
Antidysenteric Serum (Polyvalent), 214
antiserum, purified with sodium sulfate, [Garcia] 1855—ab
bacillary, relation to colitis, ileitis and granuloma, [Felsen] 2191—ab
outbreak, Illinois, 2011
DYSGERMINOMA, clinical aspects, [Fauvet] 1863—ab
DYSMENORRHEA, cause; treatment, 1412
treatment, alcohol injection, [Davis] 1428—ab
treatment, insulin, [Altschul] ★1380
treatment of primary type, antuitrin-S, emmenin liquid, progynon and progynon-B for, [Israel] ★1698
treatment, presacral nerve resection, [Bailey] 339—ab
DYSPHAGIA: See Swallowing
DYSPNEA, cardiac, [Maddox] 1769—ab
cardiac, mercurial diuretics in, [Levin] 2265—ab
DYSSYNERGIA: See Bile Ducts, obstruction
DYSTROPHY: See also Brain; Cornea
adiposogenital, 237
muscular, late progressive, [Nevin] 1770—ab
muscular, progressive, aminoacetic acid for, [Borst] 1862—ab

DEATHS

A

Abbott, Charles Shewell, 1935
Abbott, Demas Hartzell, 556
Abbott, Donald Putnam, 1218
Abbott, Nathan Wallace, 2086
Abbott, William Louis, 1835
Abeln, Joseph L., 1586
Adams, John King, 1834
Adams, Rollin Theodore, 555
Adams, Targett, 1406
Adkins, Russell Erastus, 141
Adrounie, Haroutoune Asadour, 1677
Aker, Marion Crawford, 1330
Alderman, William N., 313
Alexander, Clifford Eugene, 1751
Alexander, Sarah Marie Washburn, 556
Alkire, Herbert Lee, 2021
Allen, Howard Stanley, 1836
Allen, Robert Aurand, 2085
Allen, William Cline, 1585
Allison, Duncan, 2022
Allison, Willard Rea, 870
Almas, Joseph Seymour, 141
Amos, Henry C., 2021
Anderson, Frank T., 142
Anderson, Henry Gray, 555
Anderson, Hugh Moran, 2022
Anderson, James Albert, 1835
Anderson, John Hammond, 1835
Anderson, Robert Burns, 141
Angell, William A., 142
Ankrim, Louis F., 1511
Apple, Benjamin, 1935
Aquino, Pedro B., 1510
Arbaugh, R. C., 1836
Archibald, Charles Harvey, 1752
Archibald, Frank M., 1836
Arthur, William Hemple, 2252
Atkeisson, John Edward Hall, 1677
Atkinson, Alvan Williams, 722
Augustin, George William, 2021
Austin, Dildy McCowan, 2086
Austin, Guy Leslie, 142
Austin, James Monroe, 2174
Austin, William C., 48
Autrey, Adam M., 723
Averell, Ernest Lincoln, 2086
Ayer, Philip Edward, 142
Ayers, Clinton L., 232

B

Babcock, Bert William, 938
Babcock, Franklin Elisha, 482
Bach, Wilgus, 2175
Bacon, John Lowell, 62
Bagley, Henry Patterson, 937
Bailey, Eugene McKay, 1835
Bailey, George Troy, 1586
Bain, Walter Gelvin, 312
Baird, James Donald, 62
Baker, Edward G., 1586
Baker, Frank L., 2086
Baker, George John, 62
Baker, Henry A., 556
Baker, Julian Meredith, 61
Baldwin, Frederic William, 2085
Baldwin, James Fairchild, 870
Ball, Frederick Spencer, 232, 1506
Ballance, Sir Charles, 1325
Ballou, Ambrose Roche, 482
Balsbaugh, George Daniel, 1751
Balsley, Clyde Martin, 232
Banes, Jane Ketchum Wildrick, 870
Baragar, Charles Arthur, 1834
Bárány, Robert, 1828, 2173
Barbour, Llewellyn Phelps, 1586
Bargar, Gilbert Milton, 1110
Barker, Justin Starr, 1836
Barnes, Ida Florence, 2087
Barnes, Lord Byron, 232
Barnett, Constantine Clinton, 722
Barnett, George Gilbert, 399
Barrett, Albert Moore, 1329
Barrows, Roy Edgar, 1835
Bartholomew, Carl A., 1751
Bartlett, Clayton Elmer, 1512
Barton, Virgil Henry, 1934
Bastian, Jos. W., 62
Bates, Carlton A., 939
Battles, Mark Douglass, 62
Baucum, James Daniel, 1586
Baumgart, Frederick August, 938
Baxter, Thomas Leland, 2022
Bazet, Louis, 1584
Beach, David Benjamin, 2021
Beachy, Melvin Ellwood, 1752
Bean, Orland W., 62
Beane, George Walters, 2176
Beauchamp, Walter Lee, 1835
Beder, Morris William, 2087
Beebe, George Hatch, 1110
Beekman, Philip, 2022
Bell, Charles, 2086
Bell, Edward M., 723
Bell, James Hall, 141
Belshe, George W., 722
Benner, Robert William, 870
Bennett, Chas. Edward, 142
Bennett, John Charles, 556
Bennett, Mary M., 556
Benson, Samuel Levin, 2086
Benz, Henry Andrew, 1330
Bergman, Harry, 555
Bergtold, William Harry, 1834
Berry, John Cutting, 1407
Besner, J. Edouard, 556
Bethel, Louis Prentiss, 1512
Bethke, August Henry, 1585
Bettmann, Henry Wald, 398
Betz, Donald Armand, 2087
Bickley, George Henry, 1752
Biggs, Erle Leslie, 2087
Biggs, Vincent A., 556
Biller, John G., 2023
Bingham, George Plato, 142
Birnbaum, Frank Albert, 399
Bishop, John Hagerty, 399
Blackburn, Ida E., 1407
Blackledge, Hugh Thomas, 1586
Blackwell, Joshua Melvin, 482
Blair, Alexander McNiel, 62
Blair, Louis E., 399
Blair-Bell, William, 475
Blake, Charles Abbott, 2086
Blake, Thomas M., 870
Blanchette, Alexander, 313
Blankmeyer, Herman Henry, 313
Blanton, Ira L., 313
Blattner, Louisa Eastham, 1585
Blevins, James Daniel, 2022
Blough, Homer Chester, 1407
Blue, Irving Harold, 1512
Board, John Arnold, 399
Boatwright, John R., 1586
Boddy, James Marmaduke, 399
Boen, Albert L., 1586
Bogan, James Henry, 1025
Boggan, Patrick P., 1330
Boggess, Squire Raymond, 1407
Boles, Eugenie Ferguson, 1836
Bona, John Joseph, 2175
Bongiorno, Felice, 1586
Bonnar, William, 1836
Bonta, Maurice Buford, 313
Booth, James Arthur, 313
Bosch, Hermann, 62
Bosworth, John Woodbridge, 1110
Boucsein, Gustav F., 2087
Bower, George B. M., 641
Bower, Wallace, 313
Bowles, Loetta Beamer, 313
Bowman, John William, 1585
Bowser, Ira David, 399
Boyd, Abraham Weatherly, 723
Boyd, John R., 1219
Boyles, Augustus C., 1110
Bradbury, Samuel J., 2021
Bradford, Wm. Starling, 482
Bradley, William Little, 232
Bragg, William N., 2023
Brandon, Oscar W., 2086
Braun, George Heinrich, 2176
Braun, Harry Edgar, 62
Brehm, Theodore G., 141
Brennan, Hubert Daniel, 1934
Brennan, Thomas Leo, 1110
Brewer, Earl Donahue, 1585
Brin, Jacob, 1407
Brinker, Louis Edward, 398
Brinson, Haynes, 939
Brinton, Ward, 398
Brister, John M., 1584
Britell, Oley Alphonso, 1330
Broadbent, Donald Wright, 1330
Brodie, Martin L., 1512
Bromley, Robert Innis, 2023
Brooks, Don Dickinson, 722
Brooks, Harlow, 1511
Brothers, William Ross, 2086
Brouwer, Frank, 1219
Brown, Alice K., 232
Brown, Caroline Sophia, 1025
Brown, Ewing: See Brown, John Ewing
Brown, Francis Edward, 2021
Brown, Frank Allison, 2176
Brown, Frank Edward: See Brown, Francis Edward
Brown, George Franklin, 1586
Brown, John Ewing, 722
Brown, Perry M., 1836
Browning, Eli, 1586
Bruere, Abel T., 723
Brundage, Albert Harrison, 1677
Bryant, Benjamin Thomas, 1219
Buck, Maurice Allen, 142
Bunnell, George Lincoln, 1407
Burbank, William Winston, 141
Burden, William James, 939
Burdick, William, 232
Burgess, Walter White, 2022
Burnam, James Fulton, 1512
Burrows, Eggleston: See Burrows, Thomas Eggleston
Burrows, Thomas Eggleston, 2085
Busco, Juan, 1510
Busson, Bruno, 1216
Butler, Hiram Knox, 939
Butler, William Joseph, 62
Butz, Raymond E., 1219

C

Cahall, Wm. Cannon, 1512
Cahill, Chas. Sumner, 313
Cain, Benjamin Franklin, 2086
Caldwell, David Paul, 1835
Callen, Wm. Russell, 938
Callihan, Richard G., 399
Campbell, Edward Buckley, 1219
Campbell, George McIntyre, 1024
Campbell, Herman Berg, 1407
Campbell, Robert M., 1586
Campbell, Wm. Edward, 313
Canan, Mack Clelland, 313
Cannon, Harry, 2085
Capron, Franklin Pierce, 312
Carlock, Arley Ernest, 1512
Carpenter, Carrol Clinton, 1836
Carpenter, Howard Luxmoore, 482
Carpenter, Jessie Drew, 1110
Carr, John Harvey, 2023
Carroll, Frank, 142
Carroll, Ruth B., 1752
Carter, Charles W., 2023
Carter, John T., 2022
Carter, Phineas B., 313
Carter, Wm. McKinley, 399
Carver, Rufus Herbert, 641
Case, Iverson Clark, 313
Cathcart, Wilson Boyd, 938
Cattell, Henry Ware, 1218
Chalmers, Thomas Clark, 398
Chambers, Graham, 1935
Chandler, Augustus Wellington, 1752
Chapin, Wm. Burdette, 142
Chapman, William Day, 1677
Chappelier, Harry C., 141
Chase, Augustus Lucius, 1752
Chassaignac, Charles Louis, 1218
Chastain, Josiah S., 2022
Chauncey, Edwin M., 1677
Chidester, Walter Clifford, 2175
Christopherson, Alfred William, 641
Church, Charles Glenn, 313
Clapp, Frank Horace, 1407
Clark, Fredk. Smith, 641
Clark, George Edward, 1834
Clark, Jacob Wendell, 1110
Clark, James E., 1836
Clark, John William, 1110
Clark, Jos. J., 641
Clark, Thomas Allen, 1584
Clark, Tracy Earl, 1751
Clark, William Lawrence, 870
Clarke, Wm. Harvey, 1512
Claypool, Robert Wilson, 2176
Clegg, Christina Scott, 939
Clifton, Jos., 1752
Clingan, Andrew J., 142

Cloud, Milton Maceo, 142
Clover, Cuvier L., 1407
Cobb, Carolus Melville, 1512
Cobb, Edward Chisholm, 556
Coble, Albert H., 313
Coffield, Albert Lee, 1751
Coggeshall, Julian Terrell, 1835
Cogswell, Samuel Johnson, 1219
Cohen, John, 1407
Cohen, Joseph Samuel, 1584
Coker, Charles S., 641
Colborne, Harry Wendell: See Colborne, Henry Wendell
Colborne, Henry Wendell, 939
Colby, Emery E., 313
Cole, Charles Aldin, 313
Cole, John Plumer, 2022
Coley, William Bradley, 1511
Collings, Harry Andrews, 1835
Collinsworth, P. L., 2176
Colson, James Henry, 1677
Colwell, Charles E., 938
Colwell, Nathan Porter, 231
Combe, Frederick John, 312
Comtois, Odilon Jos., 313
Conduff, Samuel Isaac, 2021
Cone, Elbert Ernest, 641
Conerly, Cullen Clarence, 482
Connor, Emma, 2023
Connor, Harold James, 2175
Conrad, Edgar Klopp, 870
Conwell, Alfred Joseph, 2087
Cook, Frank Clarendon, 2174
Cooke, Joseph Anthony, 1219
Cooley, Cornelius Francis, 1752
Coolidge, Thomas, 2176
Coons, William Sheldon, 1024
Cooper, John, 2087
Cooper, Paul Plez, 2023
Cornelius, Daniel Richard, 2021
Cornely, James Mossop, 1407
Corwin, Chas. H., 142
Corwith, Silas Rogers, 1751
Costigan, Gregory Joseph, 62
Cott, Wm. Mason, 1584
Cottrell, John L., 232
Cox, Oscar Silas, 2022
Coy, Seth Willard, 232
Crabtree, Benjamin F., 232
Craig, Cyrus Burns, 1218
Craig, Robert H., 1835
Cramer, Martin S., 232
Cramp, Jos. A., 2022
Crandell, Latta Arthur, 2022
Crane, Charles Williams, 1834
Cranford, James Robert, 723
Cravens, Thomas R., 1752
Crawford, Thomas P., 1512
Crockett, Chas. S., 399
Croisette, Pierette, 2087
Cronyn, John Louis Chewett, 2087
Crosby, David Allen, 482
Cross, Kerr, 1406
Crouch, Hugh T., 1586
Crowe, Willis Hanford, 1834
Crowley, James Monroe, 1752
Crueger, Edward A., 1586
Crull, Eric Albert, 1677
Cullen, William Roderick, 1678
Cummiskey, Matthew Thomas, 399
Cunningham, Daniel Henry, 641
Cunningham, John Donald, 232
Cunningham, John E., 1752
Cureton, Hugh E., 1330
Curlin, Charles Wilson, 1678
Curtis, Elmore E., 722
Curtis, Frederic Chester, 1935
Curtis, John Briry, 1836
Cuthbertson, Charles Robert, 723

D

Dabbs, David Nathaniel, 1110
Dale, Charles Felix, 939
Daley, Robert Nicholas, 399
Dana, Chas. Loomis, 141
Daniel, F. E. P., 142
Daniel, Marquis E., 1752
Davenport, Francis Henry, 2176
Davidson, William Sinclair, 2086
Davis, Colbert Smith, 1836
Davis, Fred H., 1835
Davis, George E., 2085
Davis, Grover Cleveland, 2175
Davis, James Edward, 640
Davis, Lawrence Joshua, 2023
Davis, Louis J.: See Davis, Lawrence Joshua
Davis, Richard Miller Acton, 62
Davis, Vesselius, 723
Day, George Frank, 1836
Day, Walter G., 1935
DeBra, Joseph H., 1752
DeGarmo, William Burton, 937
De Lano, Frank Thomas, 2085
de la Torre, Francisco, 1510
Delcourt, Adolphe Jos., Jr.: See Delcourt, Adolphe Paul
Delcourt, Adolphe Paul, 1586
Delzell, William D., 2022
Dench, Edward Bradford, 1218
Dennis, Charles Warren, 556
de Rivas, Carlos Theodore, 231
Detar, Carm Y., 313
De Vaux, Edward F., 2086
Devine, John Andrew, 555
Devine, Winfield Scott, 555
De Voe, Arthur, 1110
Dickens, Henry T., 1110
Dill, Philip Gustav, 2087
Dill, Wm. Milton, 1407
Diller, William Edward, 2176
Dings, William H., 1835
Dinsmore, Willard Edwin, 2022
Disbrow, Harold Ball, 1678
Dixon, Charles Harrison, 62
Doctor, William Raymond, 232
Dodson, James Elias, 870
Dodson, Thomas Jefferson, 1512
Doeppers, William August, 481
Donald, David, 2022
Donaldson, Samuel, 1836
Donohue, John Francis, 722
Donovan, William Patrick, 1586
Doremus, Charles Theodore, 1110
Dorfmann, Samuel Arnold, 1752
Dorgan, Bernard Francis, 555
Dougherty, James P., 556
Douglas, James Nelson, 722
Dove, William Russell, 723
Dowd, Robt. Stewart, 556
Drewry, Thomas Ellis, 2085
Driskell, Edgar Boston, 482
Drossel, August Adolph, 723
Drummond, Robert M., 1512
Drury, Henry W., 1110
Drysdale, George Nelson, 2086
DuBois, Charles Warren, 722
Ducie, Walter Israel, 313
Duckett, Thomas H., 2023
Duel, Arthur Baldwin, 1584
Duffield, Alice Virginia, 723
Dugan, Richard Deyo, 2085
Duguid, Joseph W., 2087
Dunham, Henry Edward, 556
Dunkelberg, Elmer E., 1025
Dunkelberger, Nathaniel Z., 399
Dunlap, Florence Mary, 482
Dunn, Carl Boright, 1836
Dunn, John Benjamin, 1678
Dunn, Robert, 1512
Durant, Ira Edwin, 555
Durkin, William Joseph, 1835
Durnall, Horace W., 1752
Dutzi, August, 723
DuVal, James William, 313
Duvally, Nicholas, 142
Dwyer, Charles Raymond, 399
Dyas, Ira Everett, 556
Dyer, Abram Smith, 1512

E

Eaman, Howard Kemp, 1330
Eareckson, Edwin, 1586
Eargle, Joseph W., 938
Earnshaw, Louis Putnam, 1835
East, Omar J., 1678
Eastlake, Lewis Samuel, 1752
Eaton, Matilda, 142
Eckhardt, Wm. R., 62
Edgell, Albert M., 142
Edie, Joseph G., 482
Edmunds, Thomas Wister, 1935
Edwards, Arthur Robin, 2021
Egeland, Gustaf Richard, 1330
Eleazer, Vaughn Rhea, 1584
Elliott, Joseph Benjamin, 1407
Ellis, Joseph Cannon, 939
Ellis, Ralph Warner, 1407
Ellis, William Henry, 1835
Ellis, William Skidmore, 1585
Ellsworth, Read McLane, 2175
Emans, John Seymour, 1752
Emmons, C. Arthur, 142
Ensminger, David Wenger, 1512
Epperson, Adah, 1025
Erben, Hermann Frederick, 2087
Ernest, Clark E., 1836
Errant, Derexa M.: See Errant, Nettie D. Morey
Errant, Nettie D. Morey, 1219
Esch, Victor H., 62
Estes, Edgar Stuart, 141
Eubanks, Walter S., 62
Evans, David John, 723
Evans, Matilda Arabelle, 232
Everett, John Coleman, 555
Everson, Malcolm Wayland, 1836

F

Falk, Frederick, 399
Falk, Harry S., 1407
Fallon, Louis Fleming, 870
Farmer, Percy J., 1219
Farnsler, H. Hershey, 1751
Farquhar, Howard Lester, 1584
Farrar, Jos. Davidson, 482
Faulder, Harry B., 2087
Federman, Philip Herbert, 232
Fedorov, Serge Petrovitch, 1833
Feeney, Francis S., 1109
Feiss, Henry Otto, 1935
Feldhoff, Edward Wilson, 313
Felton, Harry Moore, 1330
Ferer, Charles Kline, 1110
Ferguson, Eugenie: See Boies, Eugenie Ferguson
Ferguson, George Bourne, 1585
Ferguson, Gowan, 556
Field, John W., 556
Finch, Frank F., 939
Fincher, Edgar F., Sr., 640
Finley, Harry Lincoln, 2176
Firestone, Samuel J., 2085
Fisher, Dennis E., 1585
Fisher, John M., 1836
Fisher, Robert Young, 939
Flannery, Frank J., 2085
Fleener, Forest Odessa Phillips, 2086
Fletcher, Henry Stephen, 1330
Flint, Clarence Wallace, 1752
Flowers, Clarence A., 555
Floyd, Wm. Oliver, 640
Flynn, William T., 313
Forbes, Albert Ernest, 2087
Forbes, Alexander Allen, 1512
Ford, Michael Joseph, 1836
Forst, John R., 62
Fortier, Camille Alphonse H., 1834
Fortney, Millard Hunter, 555
Foster, Theodore Frank, 1751
Fouts, Jesse J., 1512
Fowler, Ada A., 1330
Fowlkes, Francis Vaughan, 1330
Fox, John William, 1330
Frame, Joseph K., 482
Francis, Frank Doig, 1834
Francis, William, 556
Fredericks, David Patterson, 723
Fredericq, 1106
Freeman, Leonard, 61
Freeman, Mary, 1836
French, Malachi R., 938
Freudenberger, Harry C. A.: See Gath, Philip
Fried, Herman, 1678
Friedemann, Otto Herman, 2085
Frink, Horace Westlake, 2175
Frizelle, Clifton Horace, 2253
Frost, Robt. Samuel, 1512
Frye, Daniel Wadsworth, 1584
Fuchs, Carl Frederick B., 1835
Fuller, Emmet Lee, 1024
Fullerton, William Sommerville, 1678
Fullilove, Henry Marshall, 231
Funk, William Bernard, 1752
Funkhouser, Edgar Bright, 1219

G

Gabriel, Proceso, 1584
Gaddis, Jacob Ernest, 2023
Gailey, John Jos., 722
Gaillard, George Walter, 313
Gaines, Browder, 1025
Gaither, Fay E., 142
Gale, John Samuel, 1512
Gallagher, Condy C., 1836
Gallogly, Michael Joseph, 1934
Galster, Herman Christian, 2085
Garand, Frederick N., 556
Garland, George Pratt, 722
Garlick, Joseph Nicholas Bennett, 1751
Garner, T. J., 2087
Garred, B. P., 1512
Garrod, Sir Archibald, 1830
Garry, John Joseph, 1835
Gary, Clara Emerette, 1586
Gath, Philip, 555
Geissler, Paul Christopher, 1834
Gellhorn, George, 870
Gelsthorpe, William H., 2022
Geohegan, Wm. A., 555
Gerlach, Henry P., 1585
Getman, William Tweedy, 1751
Geyer, Harry Reasoner, 555
Ghriskey, Albert A., 722
Gibson, Wade Moss, 231
Gibson, Wm. Clement, 1407
Gilbart, Frederick William, 1585
Giles, John William, 556
Gillespie, Edwin Cyril, 1935
Glasgow, Robert Brodie, 1752
Gleason, Charles Mills, 1109
Gleaves, C. W., 723
Gliddon, Rupert William, 723
Gnasso, Enrico Raffaele, 2086
Godfrey, Erwin L., 723
Goldberg, David Dee, 1330
Goley, Wm. Roffin, 141
Goodale, Leon Harvey, 399
Goodrich, Richard Johnson, 556
Goodwin, Edward Everett, 313
Goodwin, George E., 1512
Gordon, John Fred, 2086
Gordon, Louis James, 2087
Gordon, Ralph L., 1935
Gorman, John Francis, 722
Gorman, Thomas Conner, 1330
Gorrell, Abraham Hardesty, 482
Goucher, Elmer E., 723
Gould, Jefferson, 2085
Gowan, William Alexander, 1110
Grable, Harry G., 1751
Grady, Leland Vain, 1751
Graff, Edward James, 482
Graham, Alert Rogers, 2087
Graham, Anthony W., 723
Graham, John Alexander, 1512
Gratiot, Harvey Bradley, 938
Graves, Walter John, 2023
Graves, Wildy Harding, 1407
Gray, James William, 231
Green, Charles F., 1935
Green, Edward Houghton, 555
Green, James Sproat, 1218
Green, William Henry, 1585
Green, William Henry, Jr., 2023
Greene, Robert H., 1512
Greer, John Joseph, 1330
Gregory, Calvin Levi, 482
Grimes, Charles A., 482
Grisard, John P., 62
Grubb, Albert G., 1025
Grubb, Henry Clay, 1025
Guier, Louis J., 1586
Guinane, Joachim, 2087
Guittard, Virgil David, 722
Gullic, James Franklin, 1330
Gully, Henry S., 1934
Gunderson, Carl Anton Schau, 1935
Gustine, Norman W., 2086

H

Haden, Eugene Barnard, 722
Haigler, Samuel Hart'ey, 1586
Hain, David H., 1585
Haines, William Fisher, 142
Haldane, John Scott, 1671
Haley, Dorman Elroy Elbridge, 2087
Hall, Edwin Thomas, 232
Hall, Harry Edgar, 1836
Hall, Humphrey H., 142
Hall, Joseph, 62
Hall, Laburn, 142
Hall, Lester Parker, 1330
Hall, Rufus Bartlett, 1834
Hall, Wm. A., 1512
Halliburton, Westley W., 641
Hamel, Eli Burton, 482
Hamilton, Dennett B., 640
Hamilton, Roddie J., 1512
Hammonds, James T., 1025
Hanan, James W., 1219
Hanchett, Alfred P., 399
Hanley, Erestus Talbot, 870
Hanna, David Broderick, 1586
Hanna, Frank, 1586
Hannah, James Blain, 2086
Hannah, Louis, 723
Hanson, Albert Chester, 232
Hanson, Clarence Alfred, 1025
Hanson, Knud, 1110
Hardy, George Edward Webb, Jr., 1834
Hardy, William James, 2086
Hare, Stanley R., 2085
Harkin, Fredk. McDonell, 938
Harkins, James Clement, 1218
Harmon, Samuel Eugene, 398
Harris, Elijah George, 1835
Harris, Harry Cleveland, 1836
Harris, Herrman Hirsch, 1109
Harris, Malcolm LaSalle, 1109
Harris, Robert Lee, 2085
Harris, Wm. Compton, 641
Harroun, Ezra S., 2087
Harsh, R. N. Herbert, 1585
Hart, Fenn John, 232
Hart, Henry P., 2253
Harvey, Lewis Scott, 641
Hastings, Seth Gordon, 2087
Hatchet, James King: See Hatchett, James King
Hatchett, James King, 1585
Hatchkiss, Mary M. Nelsen: See Hotchkiss, Mary M. Nelsen
Havard, Hardy David, 1110
Hawkins, William James, 1110
Hawley, Max Charles, 870
Hayden, Arthur Sumner, 1585
Hayden, Curtis Thomas, 2087
Hayes, Edward Stephen, 1935
Heacock, Raymond E., 1585
Heald, Alfred Henry, 2085
Heard, W. W., 1586
Heath, Corlin: See Snyder, Corlin Heath
Heberton, Charles M., 1836
Heckel, Edward B., 61
Hedlund, John, 2087
Heebner, Thomas Fister, 142
Heidman, A. C., 1835
Heising, Albert Frederick, 2085
Hendrickson, Helmer Andrew, 482
Hendrickson, Mary A. Keller, 2086
Henry, George Aubry, 1836
Henry, James Z., 2176
Heritage, Alfred C., 641
Herndon, Edward Frazer, 1935
Herrick, Rupert Connor, 399
Herriman, Frank Richard, 1934
Herring, George H., 641
Hershman, Abram A., 398
Hess, John Wm., 1330
Heston, Joseph Z., 399
Hewitt, Milo Ruben, 2085
Hibsman, Henry Harrison, 313
Hicks, James M., 482
Hiestand, Daniel, 723
Higgins, Pierre Francis, 312
Hightower, Thomas A., 2087
Hilbert, John A., 2086
Hill, Frederick William, 2023
Hill, Thomas Chittenden, 2175
Hill, William L., 1752
Hinman, Fred Leffinwill, 2087
Hinton, Charles Crawford, 1751
Hiscock, Robert Carroll, 1512

Hitchcock, Harry Eastman, 1110
Hixon, Frank Petty, 938
Hoag, Grace Mae Harcourt, 142
Hoag, Lynne Arthur, 938
Hoagland, Lewis B., 938
Hobbs, John Leonidas, 723
Hockman, Robert William, 62
Hodge, Alonzo Richard, 641
Hodges, John Walter, 232
Hoffman, Carl, 723
Hoffman, Conrad Rowland, 1751
Hoge, Smith A., 1585
Holcomb, Amy Amanda Decker, 1678
Holden, Edgar, Jr., 2174
Holland, David Lewis, 1836
Hollenbeck, Frank Bradbury, 2175
Holloway, Willie Paxton, 1512
Holman, Richard Stillwell, 1512
Holmes, Arthur David, 1218
Holt, Oran Cortez, 1512
Hooker, Henry Kent, 398
Hooper, Charles Warren, 937
Hooper, Charlotte Bradford: See Phillips, Charlotte Hooper
Hoover, Peter N., 2086
Hopp, George August, 2175
Hopwood, William Henry, 1025
Hoskins, Ashbel Newell, 313
Hoskins, Thomas Moore, 1836
Hosmer, Cuthbert Lynn, 1752
Hotchkiss, Mary M. Nelsen, 482
Hough, Wyman George, 482
Housholder, Addison Barrett, 2085
Houston, J. Frank, 1586
Hovorka, Wenceslaus J., 2086
Howard, C. Norman, 231
Howe, Orwin E., 399
Howland, Chas. Abel, 641
Hoyt, Daniel James, 1110
Hoyt, Hubbard McKee, 938
Hubbard, George Whipple, 1836
Hubbard, Howard Fruin, 938
Hubbard, Rockwell B., 2087
Huberti, Joseph, 939
Hudson, Cecil S., 939
Hudson, Frank Warren, 556
Hudson, James Rhodes, 2087
Hughes, Daniel Robert, 939
Hughes, William H., 1835
Hughes, William Lloyd, 1836
Hulick, George Oscar, 1110
Hull, Charles Alfred, 723
Hull, Edward Samuel, 399
Hull, James Meriweather, 2175
Humphrey, Harvey Whiting, 641
Hunt, Walter Denis, 142
Hunter, James McKnight, 142
Hunter, John C., 1586
Hunter, John T., 2176
Hurlbutt, Augustus Moen, 1585
Hurley, Joseph Edward, 399
Hussey, Millard F., 2085
Hutchinson, Henry Sinclair, 722
Hutchison, Claudius Pugh, 2086
Hutto, Omer Davis, 1109

I

Iberler, Aloys, 1511
Ibrahim, Abdu M., 1584
Iglehart, Nathan Edmondson Berry, 1329
Ingraham, Charles A., 399
Inlow, George I., 1330
Irvan, Hardin Davenport, 1752
Irvine, Alexander, 1109
Irwin, Eli Franklin, 142
Irwin, James Alexander, 1109

J

Jackson, Charles Cushing, 2087
Jackson, Greene B., 1836
Jadassohn, Josef, 1579, 2172
Jappe, Christian Frederick, 1585
Jarboe, Parran, 640
Jardine, Edward W., 2086
Jarvis, Leonard, 1407
Jeffers, Edward A., 2176
Jeffrey, Robert Harrison, 2175
Jenkins, N. A., 938
Jennings, Charles Godwin, 481
Jennings, John Ellis, 482
Jett, Joseph Cabell, 1330
Jinks, Marion W., 399
Johns, Foster Matthew, 2174
Johnson, Frank Hayes, 2085
Johnson, Gertrude Mildred, 1678
Johnson, Harry Dash, 2022
Johnson, Harry Otis, 1835
Johnson, John Howard, 2085
Johnson, John Morgan, 482
Johnson, Verner Paul, 2085
Johnston, J. Eaton, 232
Johnston, Melville Freeman, 555
Jones, Francis Gilchrist, 2022
Jones, Leander O., 1752
Jones, Lemuel Lafayette, 1586
Jones, Robert Arthur, 1586
Jones, Solomon Crittenden, 641
Judson, Andrew Rice, 62

K

Kabus, Robert Jr., 2022
Kalbfleisch, Frederick Henry, 1025
Kapinya, Michael E., 1585
Karst, Frederick August, 1835
Katz, Samuel Elias: See Katz, Siegfried Elias
Katz, Siegfried Elias, 141
Kaufman, Benzion, 2087
Kaufmann, Franklin John, 1836
Kearns, Joseph Aloysius, 723
Kearns, Thomas Albert, 141
Keene, Linwood Melrose, 1109
Keller, Crittenden E., 1752
Kelley, Charles, 1836
Kelley, J. O., 142
Kelley, Louis Lorenzo, 870
Kellogg, Edward R., 1835
Kelly, Herbert Elias, 1024
Kelly, J. O.: See Kelley, J. O.
Kelly, Samuel John Joseph, 1407
Kelsey, Russell Calvin, 1585
Kemp, A. Pierce, 1110
Kendrick, William Nassau, 1110
Kennedy, Patrick Joseph, 1219
Keppel, William Francis, 2023
Kern, Robert L., 723
Kerns, James Marion, 2086
Kerr, Norman Bond, 1836
Kerrigan, John Vincent, 1835
Kester, Alonzo A., 939
Ketchen, A. D., 1406
Kidd, Floyd Snelson, 722
Kidder, Walter Herschel, 1586
Kiesenwetter, Theodore N., 142
Kilbane, Cornelius Vincent, 141
Kilgour, Guy Godley, 1835
Kindig, Frank M., 1752
King, Frank Bozeman, 2086
King, James M., 1835
King, Judson Coleman, 2021
King, Richard L., 313
King, Walter Edward, 2022
Kingman, Edward Lyman, 1752
Kinneman, John G., 1110
Kinsey, Irwin Zepp, 641
Kirby, Ellwood R., 481
Kirby, George Stewart, 1586
Kirby, Tupper, 2087
Kirk, Ellen Maria, 723
Kirkpatrick, Thomas S., 142
Kistler, Herbert Daniel, 1834
Kite, Isaac Walter, 1677
Kittinger, Ferdinand Austin, 141
Kjos, Clarence Eugene, 2021
Klein, August Andreas, 2087
Kline, David Frank, 2087
Knapp, Herbert D., 232
Knerr, Morgan Wilson, 1512
Knewstep, William Edward, 2085
Kniffler, Oscar H., 1752
Knight, Archibald Patterson, 62
Knight, Arthur Levi, 2086
Knight, Guy Augustus, 142
Knight, Thomas Warren, 641
Knitter, Carl Ludwig Jr., 641
Knorr, John K., 641
Knowles, William Fletcher, 1407
Knox, Augustus Washington, 2174
Koestering, Herman Fred, 2022
Kohn, Frederick A., 2086
Koogler, John Floyd, 142
Kraus, Friedrich, 1579, 1832
Krauss, William, 231
Kress, Fredk. Charles, 1330
Krueger, Emil Otto, 640
Krumhar, Hazel Belle, 1219
Kuglar, Robert M., 232
Kuhn, Charles Francis, 231
Kulp, Horace Landes, 2086
Kunin, Albert S., 2023

L

Labadie, James R., 1836
Lafleur, Jules, 142
Lamb, Frank Temple, 939
Lamb, Isabel Haslup, 938
Lamb, Joseph Aloysius, 1752
Lancashire, James Henry, 2086
Lander, Jesse Harper, 482
Lane, Harry Samuel, 2253
Lange, Robert David, 2022
Langs, Major Henry, 1935
Laperriere, Germain, 2087
Lapham, Mary E., 1752
Larche, Lucien Eldred, 399
Lare, Harry S. P., 1836
Largent, Benjamin Franklin, 1329
Latham, Ortive E., 1836
Lathrop, Homer Riale, 231
Lawrence, Nellie Louise, 2086
Lawrence, Wm. John D., 399
Lawson, John Alexander, 1110
Lawton, Daniel George, 1836
Leahy, Sylvester Richard, 1218
Leary, Joanna Gaston, 1330
LeBoutillier, Theodore, 1511
Leckrone, Ira, 1109
Lee, Delzie Roy, 870
Lee, William Henry, 2087
Leeson, John D., 1110
Leigh, Southgate, 937
Lemieux, Israel, 62
Lenfestey, Fred Kittredge, 1752
Leonard, Francis George, 1407
Lerner, Henry, 2021
Leslie, James Frank, 1836
Leslie, William Henry, 723
Leslie, William McClure, 2085
Leverett, John, 2021
Levy, J. R., 1512
Levy, Murray Morris, 1511
Lewis, Clarence Linden, Jr., 1752
Lewis, Edgar A., 722
Lewis, William Gabriel, 939
Lewis, William Henry Harrison, 1024
Liddell, Tully Joseph, 938
Liftchild, Judson, 62
Lightner, Samuel Cary, 1024
Lillard, Gustavus Dedman, 399
Lindsay, James Arthur, 1935
Linfield, Edwin Harper, 641
Linger, Earl Albert, 870
Lingle, Willis Edward, 2176
Linville, Solomon Milton, 399
Lipphard, Alvin T., 231
Lipscomb, Robert Scrivner, 1512
Little, George Richard, 1407
Lloyd, John Uri, 2013
Lloyd, Sara J., 399
Lockie, George David, 398
Long, Albert Anderson, 1752
Long, John Pomfret, 938
Long, Stephen Madatian, 723
Longley, Israel Fletcher, 723
Longwell, Harold Walter, 1219
Look, Henry Harve, 2085
Loose, Chas. G., 482
Lott, Henry Stokes, 2086
Louchery, Daniel Carson, 1024
Loughran, James Joseph, 1935
Love, George Robert, 723
Love, Matthew T., 1025
Lovell, Carroll Monroe, 399
Lovett, William Robert, 313
Loving, Royal Shepherd, 1584
Lovitt, Israel Melbourne, 723
Low, George Earl, 641
Lowell, Frank Sumner, 1752
Lucas, William Chisolm, 2087
Luck, Paul Maximilian Karl, 1678
Ludlow, Edwin W., 722
Luke, Frank Edmund, 1024
Lunn, William Beatty, 2175
Lupin, Emanuel J., 2087
Lutman, Harry Nelson, 313
Lyle, William Clifton, 2252
Lynch, Ransom B., 2176
Lyons, Fowler, 1585

M

Maas, Monroe Aaron, 1024
Mabee, John Ralph, 1836
Macer, Thomas, 1836
Mack, William E., 1512
MacLeod, Mary Elizabeth, 723
MacMillan, Mary, 2087
MacMillan, Wm. D., 313
MacNeillie, J. C., 1406
MacPhee, L. Lee, 2087
Maddock, Louis, 2253
Maddox, Stephen Edward, 1586
Maeder, John Samuel, 2175
Magee, Astus S., 938
Maguire, C. Frank, 142
Maguire, James Bernard, 2021
Mahoney, Francis Xavier, 640
Main, Frederick William, 2086
Mambert, Adelbert Henry, 1678
Manes, William H., 1752
Mangham, John Drewery, 142
Marbarger, George S., 1584
Marchiafava, Ettore, 1022
Marden, Tilghman Brice, 1835
Maresch, Rudolf, 106
Marion, George Louis, 1512
Mark, Nellie Virginia, 723
Markley, Lemon R., 2023
Marotte, Charles Louis, 2253
Marrs, Richard F., 2021
Marsden, Henry Irving, 1025
Marshall, Alvis Taylor, 1935
Marshall, Cuvier Robb, 232
Marshall, Robert James, 2252
Marshall, Thomas Rollins, 1751
Martin, Walter D., 1585
Mason, Charles North, 1110
Mason, James Tate, 2252
Massey, John Fletcher, 641
Masten, Edson W., 723
Mathews, Frank Stuart, 1329
Matsumura, Kiyoshi, 938
Matthew, John Benjamin, 2087
Matthews, James Arthur, 2176
Mattingly, Arthur R., 938
Maulsby, Ellis P., 142
Maxwell, Herbert Bowen, 2087
May, George Francis, 641
Mayburry, Walter Fullarton, 556
Maycock, Burt J., 482
McAllister, Frederick Danforth, 1834
McAlvin, Eldrige G., 1219
McBride, John Leaming, 1585
McBride, William Otis, 231
McCabe, William Otey, 1330
McCaleb, William Edward, 1024
McCallum, Archibald, 399
McCarthy, Earl Roach, 2253
McCaskey, Francis Howard, 1024
McCaskey, George Washington, 481
McClain, Marion Cicero, 870
McClendon, Charles C., 1512
McClure, William Bradbury, 870
McCollum, Wm. James, 640
McConkey, Clarence Marion, 1330
McConnell, Pascal Whitney, 1219
McConnell, Thos. Ethelbert, 1584
McCorkle, John A., 2023
McCorkle, Milton G., 556
McCormick, Thomas Allen, 2253
McCown, Ernest Kingsley, 1025
McCracken, George Alexander, 1330
McCready, John W., 1935
McCurdy, Lawson A., 723
McDermott, Joseph L., 1834
McDonald, Chett, 1678
McDonald, Ernest Augustus, 723
McDonald, Stephen H., 1934
McDonough, Edward James, 722
McDuffie, James Henry, Sr., 312
McElhannon, Marcus K., 556
McGee, Albert Corryden, 1836
McGee, Donald Badenoch, 1585
McGill, Wm. Porter, 556
McGinness, Isaac L., 1836
McHenry, Joseph Bostock, 939
McHugh, James E., 723
McKay, Hugh Alexander, 1752
McKibbon, Fred William, 1752
McLaren, David Cummings, 641
McLaughlin, Henry Valentine, 2022
McLaughlin, John Joseph, 641
McLean, Isaac N., 142
McLean, John William, 1835
McLeay, John Alexander, 1835
McLennan, Donald Randolph, 1678
McMahan, Jerre C., 870
McMillen, Robert M., 312
McMorrow, Frank, 2022
McNally, Allan, 1586
McNamara, James Herbert, 1935
McRae, Earle Hobart, 1023
McRoberts, William John, 313
Meade, Frank Sherwood, 1834
Meek, Francis Joseph, 1512
Meighen, Jacob Wells, 641
Meitin, Ruth, 2022
Memminger, Allard, 1109
Merrill, Edward Roscoe, 1407
Merrins, Edward Michael, 2022
Messick, William Irvin, 641
Method, William Arthur, 1110
Michael, Jeffrey Charles, 870
Michel, George Peter, 1330
Miller, C. Jeff.: See Miller, Charles Jefferson
Miller, Charles Jefferson, 1218
Miller, Emery Austin, 1834
Miller, George Andrew, 232
Miller, Herman Benjamin, 232
Miller, Horace Winter, 2086
Miller, Hubert Livingstone, 640
Miller, Joseph H., 641
Miller, Russell Eugene, 1835
Miller, Samuel B., 232
Miller, Samuel Nelson, 723
Miller, Samuel P., 1836
Million, Joel Bartleson, 232
Mills, Charles D., 141
Mills, Charles H. C., 1752
Mills, Daniel Guy, 1511
Mills, Evan C., 722
Milton, Philip Elington, 142
Minor, Chas. L., 1330
Minor, James Cabell, 1935
Minter, Russell Ellis, 2253
Mitchell, Winthrop Dodd, 722
Moakley, Robert Clement, 1330
Moeller, Charles L., 2087
Moll, Carl Fredric, 1751
Monroe, Dana Elbra, 641
Montague, Seth Jones, 1110
Montgomery, Howard M., 142
Mood, Julius Andrew, 1024
Moon, Roy, 141
Moore, Frederick Atkins, 1219
Moore, James Carlisle, 232
Moore, Robert Worth, 1407
Moore, Thornton Austin, 1219
Moran, Thomas, 939
Moran, William, 1511
Morey, Nettie D.: See Errant, Nettie D.
Morgan, John Richard, 1835
Morgan, Thomas Richard, 313
Morret, Henry Eckert, 313
Morris, Andrew Jackson, 2253
Morris, Emory Arnold, 142
Morris, Geoffrey Marshall, 1678
Morris, George Patrick, 938
Morris, James T., 232
Morrish, Edward, 232
Morrison, Henry Edwin, 1835
Morrison, Moses Alexander, 1219
Morse, Alpha Raymond, 1834
Morse, Frank Waldron, 142
Mortimer, Egbert Laird, Sr., 722
Morton, William Wade, 313
Mosher, Edith Lyall Maddren, 2253
Moss, Abraham, 1512
Mothersill, George Sidney, 2022
Mountain, John Henry, 1678
Mountain, Wm. Henry, 232
Moyers, Isaac Newton, 1025

Mueller, Carl F. M., 232
Mullen, Thomas Francis, 2175
Munro, Dugald D., 2023
Murcutt, Florence Josephine, 723
Murphy, Andrew, Jr., 2253
Murphy, George Stewart, 1585
Murphy, Timothy Jos., 722
Murray, Peter, 1835
Murrell, Ulysses Grant, 1219
Muse, James Madison, 1752
Musgrove, Joseph Schwartz, 1586
Myers, Joseph, 2022

N

Neagle, Alexander Hill, 556
Nealon, James M., 1110
Neas, Adolph J., 1586
Neff, John Alexander, 556
Neipling, Clarence E., 232
Nelsen, Mary M.: See Hatchkiss, Mary M. Nelsen
Nelson, G. W., 2086
Nemet, Geza, 2021
Nesbitt, William S., 2086
Ness, William, 2023
Netter, Arnold, 1325
Nettle, Mary Anna Israel, 1585
Neuberger, John, 1024
Nevin, John, 2253
Newman, Jacob Warren, 2021
Newnam, Henry Joseph Eugene, 1584
Nichol, David Harvey, 2022
Nichols, John Oliver, 938
Nickson, Chas. Edward, 398
Nicolle, Charles Jean Henri, 864
Nixon, John Sater, 482
Nixon, Robert T. A., 2253
Nixon, Sater.: See Nixon, John Sater
Noble, Lucian L., 232
Noone, Vincent Joseph 939
Norcott, John C., 1586
Norrish, Henry William, 2253
North, Emmett Pipkin, 61
North, Will Carleton, 142
Northrop, Herbert L., 1751
Norton, Arthur C., 2022
Novinger, Jefferson T., 1512

O

Oates, William Henry, 1584
Oatman, Homer Clifton, 722
O'Brian, John Thomas, 1586
O'Brien, Francis Edward, 1752
O'Brien, Stephen F., 1586
O'Connell, George Gansey, 722
O'Connor, James Bernard, 398
O'Donnell, Earl William, 1585
Officer, Wm. Carson, 722
Ogden, John Percy, 1935
Ohage, Justus, 870
Okajima, Keiji, 2174
O'Leary, Albert Patrick, 1024
Oliaro, Guglielmo, 2020
Oliveros, Bartolo Pedro, 2022
Olmstead, Edwin B., 1836
O'Mara, Thomas Joseph Grant, 2087
Oredson, O. A., 399
Orr, H. W., 2087
Orr, Robert Harris, 1025
Orr, William P., Jr., 1024
Osborn, Wells M., 1935
Osborne, Charles Kelsey, 2023
Osborne, James C., 2022
Osincup, Frank A., 1585
Ovenshire, Byron Heston, 2087

P

Pack, Henry B., 641
Packard, Horace, 1330
Packer, George Wm., 1585
Paez, S. Madrid, 1510
Page, George E., 142
Paige, Charles Henry, 1586
Pantzer, Hugo Otto, 1330
Pardee, Mark O., 1330
Park, Theodore James, 1025
Park, William Frederick, 1025
Parker, Charles Fulton, 1024
Parker, Charles Wickham, 1110
Parker, Ralph H., 232
Parks, Lewis Bernhard, 399
Parrish, J. Willard, 1330
Parrish, William P., 641
Partree, Homer Tomlinson, 641
Pascarelli, Carlo, 556
Patrizi, Luigi Mariano, 310
Patten, Stephen Kerr, 1110
Pavlov, Ivan Petrovich, 1833
Payne, Elkanah, 1586
Peacock, Silber Charles, 398
Pedrick, Charles Dun, 1219
Peebles, Joseph E., 142
Peeples, Darling L., 556
Pellissier, H., 1406
Pemberton, Russell, 62
Pendell, George D., 1586
Pendleton, Grant Wallace, 1752
Pennoyer, Nelson Alonzo, 1024
Perkins, Percy Augustus, 1751
Perkins, Roger Griswold, 1834
Perkins, Samuel Luther, 1752
Perry, Arthur Henry, 2021
Pershing, Howell Terry, 555
Petersen, Christian Edward, 2022
Peterson, Emily C., 2087
Peterson, Nichols, 2021
Petty, Frank F., 1935
Pfoutz, Gilbert B., 938
Phelps, Albert W., 1752
Phelps, Olney Windsor, 555
Philbrick, Charles S., 482
Phillips, Charlotte Hooper, 1219
Phillips, Edgar Warden, 2252
Phillips, Everett E., 2087
Phillips, Forest Odessa: See Fleener, Forest Odessa Phillips
Phillips, Henry Frank, 556
Phillips, John Henry, 2176
Phillips, Thomas Charles, 938
Pierce, Alano Eleno, 1835
Pierce, Harry M., 1512
Pietrowicz, Stephen Roman, 481
Pihlblad, Arvid, 2087
Pindar, L. Otley, 1330
Pine, Alcinda Auten, 1512
Pines, Jacob Darwin, 1025
Piper, Robert Lawrence, 1752
Pisor, Oliver Perry, 870
Pitcher, George Sawyer, 2085
Pitcher, Zina, 313
Podlasky, Harry Bernard, 141
Poland, Joseph, 1024
Polk, John Knox, 2087
Pollett, William Enoch, 2087
Ponder, Edgar Tolman, 482
Poole, George Baxter, 939
Pope, Henry Theodore, 1024
Porter, Matthew, 555
Porter, Otho D., 1512
Porter, Sidney Dale, 1219
Post, Howard Isaac, 313
Potter, Palmer Augustus, 2022
Powell, John H., 723
Powell, Millard F., 1110
Powers, Thomas Wilson, 1586
Powers, William A., 1836
Pratt, Frank Pierce, 2087
Pratt, H. Fuller, 142
Prendergast, David Aloysius, 555
Prendergast, James Francis, 232
Prevost, Charles A., 1935
Price, Walter Dixon, 482
Pride, Wm. T., 399
Probasco, Luther Green, 641
Pronger, Emma Jane Davies, 2022
Proudfit, Samuel Riddle, 2022
Pyott, Frank, 2087

Q

Qua, Julia Kimball, 1935
Quigley, William J., 2086
Quin, Joseph Francis, 1935
Quintard, Edward, 1023

R

Radcliffe, McCluney, 1219
Ragsdale, George W., 2086
Rahte, Walter Eugene, 1330
Rains, John M., 62
Ramey, Frank, 1330
Ramey, Winston Garfield, 1110
Ramos, Nicholas Ignacio, 2086
Randall, Samuel John, 1836
Randall, Thomas Jefferson, 2176
Randle, Henry Carlyle, 1512
Rathbun, William T., 1025
Rawlings, Junius Ambrose, 2086
Ray, Franklin Elmore, 640
Ray, Robert Bentley, 313
Rebman, Emory Chester, 1024
Reed, Elias Wilbur, 1934
Reed, Wm. Burt, 1219
Reed, Wilson H., 2087
Reeks, Thomas Eben, 481
Reid, Charles Scott, 142
Reid, William, 2023
Reifels, Louis Fred, 482
Reik, Andrew Jackson Neilson: See Reik, John Neilson
Reik, John Neilson, 1677
Reist, Claude Owen, 1110
Rembert, John Jesse Carroll, 1586
Rennison, Nicklaus Albert, 1219
Rescigno, Gaetano, 2086
Revington, John Hamilton, 1024
Reyher, Christopher M., 1751
Reynolds, John Leonard, 2087
Reynolds, Milton E.: See Reynolds, Milton H. E.
Reynolds, Milton Herbert E., 1935
Rhamy, Lester Bogue, 398
Rhein, Robt. Davies, 1511
Rho, Filippo, 140
Rhodes, Sylvan Elzanie H., 1025
Rice, Florence Frances, 2022
Rice, Hudson D., 2176
Rice, William Edgar, 722
Richardson, David Herbert, 2085
Richardson, George W., 938
Richardson, Walter Jay, 1934
Richardson, William B., 1110
Richer, Jacob D., 2023
Ricker, Sumner J., 938
Ridley, Robert Berrien, 482
Ridlon, John, 1677
Rigdon, Rufus Lee, 1024
Rinde, Hamilton, 1024
Riordan, James Coad, 1585
Risen, Wm. James, 1407
Ritter, Wm. Elmer, 313
Rivarola, Rodolfo A., 1510
Rivenburg, Sidney White, 2087
Roath, Clinton, 1219
Robb, Wm. John, 556
Robbins, Edward Louis, 1678
Roberts, Fredk. Alpha, 399
Roberts, Stephen Martindale, 62
Robertson, James Douglas, 1025
Robertson, L. K., 1586
Robertson, Peter B., 723
Robinson, Fred William, 2175
Robinson, Goldsmith P., 1025
Robinson, Mary Emma Bliss, 1836
Robinson, William Josephus, 938
Rockwell, George Ward, 1935
Rodes, Landon O., 939
Rogers, Frederick Willard, 1935
Rogers, Jerome Bonaparte, 1835
Rogers, William D., 1330
Roland, John Levi, 313
Roland, Marion Mansfield, 61
Roller, Louis Alfred, 2021
Rominger, Louis, 938
Rosat, Lina M., 2176
Rosenthal, Maurice I., 555
Rosoff, James A., 1109
Ross, Fulton Thomas, 556
Ross, Hugh Prescott, 1109
Rothfuss, Guy Huffman, 1512
Rothschild, Marcus Adolphus, 1023
Ruble, William Kent, 939
Ruffin, Willcox, 1935
Ruiz, Fernando, 1510
Rumph, John Mitchiner, 723
Runkle, Stuart Calvin, 723
Runnalls, Thomas Harris Boyle, 723
Russell, Frank Eugene, 312
Russell, Thomas Jackson, 2175
Rust, Edwin G., 1024
Rutledge, William Stowe, 722
Ryan, Edward J., 555
Ryan, Michael Lawless, 2021
Ryder, Charles Edward, 1407

S

St. Clair, John M., 2176
St. John, Horace Henry Hosford, 556
Saleeby, Najeeb Mitry, 1586
Salmon, Robinson Herman, 2176
Sample, Robert Lewis, 2022
Sampson, Allen Gray, 556
Sams, James W., 1330
Sanborn, Fletcher Greene, 1407
Sanborn, Josiah Lane, 2176
Sanford, Albert Allen, 556
Sanford, Alton, 1836
Santee, Harris Ellett, 1109
Saunders, George, 313
Schaefer, Theodore William, 2174
Scheffler, Felix John, 556
Scheibenzuber, Dagobert A., 1835
Schiller, Leopold, 482
Schlegel, Gustavus, 2021
Schminky, Gurney Monroe, 313
Schneider, Adam Lawrence, 141
Schnell, Joseph H., 641
Schnetz, Thomas Nelson, 641
Schoales, Charles B., 2022
Schroeder, Leo Adelmo, 62
Schwenk, Clayton S., 482
Scott, Cyrus Wallace, 556
Seabrook, Alice Mary, 1584
Seagrave, Mabel, 141
Sears, John L., 62
Seashore, David Edward, 62
Seidler, William Fred, 1585
Seigle, Stanley Arnold, 2086
Seiler, John Henry, 2175
Selleck, Arthur Warren, 1935
Semple, James, 2176
Seufert, George John 1752
Sharp, John G., 1512
Shauck, Albert Gus, 1935
Shay, James Joseph, 62
Shearer, Wm. Alexander, 723
Shelton, Rawley Martin, 2176
Sheridan, Philip Joseph, 1584
Shields, Edmund, 939
Shirk, George Wynn, 1836
Short, Jacob Lindsey, 1585
Shriver, John Milton, 723
Shuford, Jacob Harrison, 722
Siberts, Paul Raymond, 556
Sidlinger, Samuel Hoffman, 555
Silliman, John Calvin, 62
Simms, Benjamin Brittain, 2174
Simonds, Clarence Eugene, 2252
Simpson, Josiah Adams, 1586
Sista, Charles Richard, 2021
Sitton, Wm. Homer, 1330
Siver, Emett Lucien, 2253
Skaggs, Joseph Ellis, 1219
Skillern, Wm. Franklin, 723
Skinner, James Wallace, 1935
Slaughter, Myles Jasper, 2176
Sloan, Baylis Frank, 2175
Slote, Samuel H., 1110
Small, Lawrence Madison, 2176
Smartt, Marcus Polk, 1511
Smiley, Harold Everett, 2253
Smiley, Robert Borden, 2175
Smith, Arthur Ernest, 555
Smith, Charles Purnell, 1586
Smith, Clarence Follett, 1836
Smith, George Carroll, 2086
Smith, Guy Addison, 2176
Smith, Howard Franklin, 2176
Smith, John Mell, 2021
Smith, John Morgan, 1751
Smith, Lynn Carl, 555
Smith, Mark Barton, 556
Smith, Millington, 640
Smith, Montague Albert Blowers, 482
Smith, Patrick A., 232
Smith, Rea Everett, 640
Smith, Stanley Sinclair, 398
Smith, Webster Stanley, 1511
Smith, Wm. Duncan, 556
Snell, John Abner, 1834
Snow, Leslie Woodruff, 399
Snowwhite, Thomas Henry, 398
Snyder, Corlin Heath, 939
Snyder, John Franklin, 2175
Sommer, Ernst August, 1329
Sorrels, Byron C., 2176
Sorteberg, Edward Donald, 1110
Souder, Lewis Reed, 62
Soule, Adeline Goodrich, 2176
Souter, Wm. Norwood, 141
Spawn, Myron G., 938
Speiden, Edgar, 2176
Spencer, Orson Bailey, 62
Spencer, Walter Valentine, 142
Spoon, Arthur Ogburn, 555
Spottiswood, John Joseph, 1330
Spradling, Lewis Wetzell, 1512
Stafford, Alburn Matthias, 1110
Stalb, Otto William, 1025
Stalsby, James David, 232
Stammel, Julius Gerhart, 723
Stanley, Joseph Bynum, 2021
Stapler, Andre Leopold, 1935
Stark, Maurice Albert, 938
Starkweather, Carlton Lee, 556
Starr, Henry E., 49
Starr, Nathan, 2021
Steadman, Evan Thomas, 1834
Steese, Edwin Sturtevant, 1836
Steeves, Edward W., 2175
Steinwinder, Charles David, 312
Stem, Grover Augustus, 1330
Stephens, Edward Buckminster, 2176
Stephens, George Whitfield, 2252
Stephens, Samuel Herbert, 2176
Stephenson, Charles Norris, 555
Steuart, W., 1406
Stevens, Herbert J., 1512
Stewart, James Jackson, 939
Stewart, John Tandy, 2086
Stewart, Peter, 938
Stewart, William F., 938
Stockbridge, Alberto Horatio, 723
Stoddart, Alfred P., 2023
Stone, Isaac Scott, 870
Stone, John Nelson, 2176
Story, Albert Hamilton, 1585
Stovall, Charles Theodore, 1407
Stowell, John Matson, 870
Strashun, Aaron, 2023
Strauss, Arnold E., 62
Striegel, Raymond John, 1586
Strite, Clarence Edward, 1934
Strong, Thomas Morris, 1025
Strunk, John Peter, 1586
Stuart, Clark Abbott, 2176
Stuart, Thomas H. D., 1836
Stuessy, Milton Franklin, 141
Sturgill, Charles, 939
Sudler, John Ralston, 2086
Sullivan, Bayard, 1586
Sullivan, George Francis, 641
Sultzbach, Henry Miller, 1585
Sumney, Herbert Clayton, 231
Surber, Casius Clay, 2176
Sutherland, P. Norman, 556
Sutton, Frederick M., 723
Sutton, Laurence Fredk. Vincent, 62
Swango, L. K., 641
Swanson, Edwin Oscar, 2176
Swarts, John Edgar, 556
Sydenstricker, Edgar, 1102
Sykes, Herbert D., 141
Szudrawski, Szymon, 870

T

Takahashi, Gonzaburo, 2174
Talbott, William E., 1935
Talley, Charles Francis, 1934
Tallman, George Davidson, 1586
Tanner, John Sumter, 142
Tanno, Guiseppe: See Tanno, Jos.
Tanno, Joseph, 399
Tate, Joseph A., 1110
Tatham, Charles Carlyle, 723
Taylor, Anna Laura, 1835
Taylor, Arthur John, 1585
Taylor, Edgar F., 2176
Taylor, Eli, 1110
Taylor, Frank Woodland, 1219
Taylor, John W., 2023
Taylor, Jos. Edward, 62
Taylor, Leslie George, 1935
Taylor, Samuel Addison, 1752
Taylor, William Johnson, 870
Teachnor, Wells, Sr., 2252
Teter, Daniel Patrick, 1024
Teter, Jacob Phares, 62
Thayer, Walter Nelson, Jr., 555
Thomas, Burr C., 1219
Thomas, Maurice Ernest, 723
Thomas, Seth Newland, 1677

Thomas, William M., 1935
Thomason, Henry Denny, 1751
Thompson, Alexander Frank, 1934
Thompson, Edward Henry, 232
Thompson, Frank B., 1678
Thompson, James Edward, 1935
Thomson, Curtis Harrod, 1219
Thomson, John Joseph, 722
Thorndike, Wm., 398
Thorning, William Burton, 1023
Thorpe, F. Nolan, 399
Thurman, William Lowell, 1935
Tibbetts, Hermann K., 482
Tidd, Charles Clyde, 2176
Tidd, Ralph Martin, 2176
Timerman, Harris E., 2176
Tinsley, Gabriel N., 1512
Tinsley, James H., 1219
Todd, Frank Lester, 2252
Tomlin, William S., 1109
Tomlinson, Edward, 2176
Topper, John Albert, 1678
Torey, Edgar James, 1835
Towle, George Henry, 62
Townsend, Daniel John, 2175
Townsend, Frederick Warder, 1407
Townsend, Smith James, 2176
Toy, Samuel Holt, 2086
Tracy, Dwight Wallace, 2174
Trail, Allen J., 1512
Traverso, Daniel, 1219
Travis, Edward A., 938
Trigg, Francis Marion, 2176
Trumbauer, Charles Andrew, 1110
Tucker, George W., 1110
Tucker, Willis Leroy, 399
Tuholske, Morris C., 1935
Turi, Pasquale Leonard, 1219
Turner, Rolland Vincent, 1024
Tyner, James Robert, 2175
Tyson, Henry Hawkins, 2252

U

Ulmer, Stephen Edward, 938
Underhill, Frederic Theodore, 2086
Updegrove, Jacob D., 2175
Upjohn, James Townley, 1024
Ury, John Francis, 722

V

Vail, Charles Edward, 1834
Vance, John Harris, 1109
Van Magness, Benjamin, 62
Van Nuys, Franklin Bache, 1110
Van Nuys, John Chauncey, 2175
Van Osdol, Dawson Dwight, 2175
Van Patten, Clyde Leslie, 1025
Vansant, John Thomas, 1586
Van Sweringen, Budd, 231
Van Tine, John Lewis, 1024
Van Valkenburg, Frederick Wanton, 1836
Vertin, Joseph David, 2087
von Haitinger, Kalman S. C., 1219
von Wedekind, Luther Lochman, 1024
Vores, Cyril Preston, 142
Vosburgh, Charles Augustus, 2253
Vowinckel, Ferdinand Wilhelm, 1511

W

Wade, George B., 1586
Wadsworth, Alfred Edwin, 1024
Wagner, George C., 1935
Wagoner, Edward Dewitt, 398
Waite, George Robert, 2023
Walden, Reavill Millard, 232
Walker, Peter Eckel, 1935
Wall, Homer Augustus, 1585
Wallace, Charles Hodge, Jr., 2021
Wallace, William H., 2023
Wallace, William Lewis, 555
Walls, Louis Lynn, 1512
Walter, Jacob A., 2175
Walter, Lorenzo, 2021
Walton, James Stanislaus, 1934
Ward, Ernest Leslie, 939
Ward, Francis M., 1835
Ward, John Vincent, Jr., 1330
Ward, Samuel R., 1407
Ward, William Douglas, 2021
Warner, Mansfield William, 1025
Warren, Arthur Jay, 1934
Watkins, Charles Franklin, 1751
Watkins, Lewis W., 1512
Watson, Roy Seymour, 640
Watson, Thomas S., 2023
Way, Osmon Franklin, 1935
Webb, Chas. Shepherd, 399
Wedemeyer, Gustave Adolphus, 1110
Welland, Carl, 232
Welland, Edward E. G., 641
Weinfield, Louis M., 1584
Welker, Abraham T., 1585
Weller, Cyrus Burford, 399
Wells, Francis Allen, 1934
Wendt, Edward Shafer, 938
Wenger, William H., 1024
Wenning, Wm. Henry, 937
Wentworth, Benjamin Franklin, 1935
Westhaeffer, Horace Emlen, 1752
Westmoreland, Willis F., 398
Wheeler, Alfred Minot, 556
Wheeler, Ira Abbey, 1219
Whetzel, Frank F., 1935
Whitaker, George Francis, 62
Whitbeck, Brainerd Hunt, 1677
White, Abigail Grace, 1512
White, George, 641
White, James C., 556
Whiteside, Edwin Eugene, 1835
Whiting, Fenton Blakemore, 1219
Whitley, George M., 313
Whitmore, William Cotman, 2085
Wichterman, Ernest Jacob, 482
Wieder, Henry Strauss, 2253
Wier, Joseph Elmore, 1751
Wilcox, Robt., 399
Wilder, Charles McDuffy, 232
Wildman, Arthur, 231
Wiley, Frank M., 2175
Wilhoit, Dennis, 556
Wilkins, George Lawson, 232
Willard, Thomas Hinckley, 1219
Willey, Felix Jefferson, 2176
Williams, Benjamin C., 1586
Williams, Clara Louise, 556
Williams, Francis A., 556
Williams, Harry Reginald, 2022
Williams, James Albert, 2175
Williams, Robert Cleveland, 1110
Williams, Wilbur Warren, 1024
Williamson, George Washington, 1511
Willis, Albert, 2253
Willis, Daniel Oscar, 938
Willis, Omer M., 1330
Wilmer, William Holland, 1023
Wilmot, LeBaron Botsford, 399
Wilson, Charles Tom Cook, 2086
Wilson, Marcus Earl, 2022
Wiltbank, Rutledge T., 723
Wine, Joseph Milton, 2176
Wink, Helena Knauf, 1584
Winter, William G., 1751
Wire, George E., 1836
Wishard, Ernest Elmer, 399
Wissig, Simon Leo, 2253
Woller, William Frederick, 1110
Womack, James Abram, 2175
Woodbury, Wiley Egan, 1024
Woods, Thomas J., 2023
Woodward, Albert Franklin, 2022
Woodward, James Claude, 2253
Worcester, James Newbegin, 1024
Worley, Luther F., 399
Wormley, Harry Ralph, 398
Woutat, Henry G., 398
Wright, George Hermann, 555
Wright, James Thomas A., 1836
Wright, Joseph Theodore, 723
Wyche, Charles, 1586
Wyman, DeLacy Evelyn, 1512

Y

Yates, William Shaftner, 2175
York, A. Bromley, 2176
Young, Claudius Junius, 2176
Young, John Keen, 556
Young, Thomas McKendrie, 142
Young, Wm. Edward, 232

Z

Zeit, Fredk. Robert, 61
Zeno, Artemio, 1510
Zimmerman, Henry A., 2021
Zinninger, Henry Albert, 1512
Zitron, William, 2022

E

EAR: See also Deafness; Hearing; Nerves, auditory; Otolaryngology; etc.
Hospitals: See Hospitals
Inflammation of the Middle Ear: See Otitis Media
internal, disturbances, 1410
middle, neoplasms involving, [Schall] 251—ab
middle, relations to focal infections of Billings, 140
Murmurs: See Tinnitus
EASTMAN Dental Dispensary: See Dental
Masseur: See Prostate massage
EATING: See Food
Utensils: See Glassware
ECHINOCOCCOSIS: See also Bones
homeless dogs and, 396
ECLAMPSIA, patients wanted at Chicago Lying-In, 2164
placental theory, [Ulesko-Stroganowa] 965—ab
puerperal, [King] 577—ab
treatment, chloral dosage, 2256
vascular aspect, [Irving] 1761—ab
ECONOMICS, cost of syphilis to community, 643
depression, diets of families with low incomes, 1201—E
depression, effect on nutrition of American people, [McLester] ★1865
problem of diet of the poor, 1213
ECONOMICS, MEDICAL: See also Insurance; Medicine, state
ascent of the medical profession; reply to H. J. Laski, [Shurly & Bullock] ★297
Care of Indigent: See Medical Service
Medical Credit Service Bureau of Sedgwick County, Kansas, 544
memberships in professional societies, [Dickinson] 144—C
social scientists in medical field, 124—E
ECTODERM: See Skin
ECZEMA, chronic, on back of neck, treatment, 1591
definition and etiology, 468—E
history taking in, [Rackemann] ★976
injurious effects of sodium chloride, [Keining] 158—ab
treatment, unsaturated fatty acids in, [McClendon] 64—C; (reply) [Taub & Zakon] 642—C
EDEMA: See also Ankle; Ascites; Dropsy; Heart; Lungs
allergic, of scrotum, 645
menstrual; controlled by emmenin, [Atkinson & Ivy] ★515
Nephrotic: See Kidney disease
treatment, ammonium chloride, [Kanfor] 2206—ab
treatment, improvement of Southey's tubes, [Leech] ★1895
unilateral, 238
EDMANDS Electric Baker, 1008
EDUCATION: See also Children, school; Physical Education; Schools; Students; University
American Council on, listing of motion picture films, 931
reform proposed in intermediate schools in Japan, 311
EDUCATION, MEDICAL: See also Graduates; Internships; Schools, Medical; Students, Medical
A. M. A. Annual Congress on, 299; 1095; 1204; 1316; 1392; 1498; 1569
consistency vs. chaos in, [Bierring] 1097—ab
curriculum and aims compatible? [Porter] 1318—ab
curriculum, anesthesia being neglected, [Schwartz] ★1445
curriculum changes advocated, [Lyon] 1499—ab
curriculum, proposed changes, Italy, 230
curriculum, radiology in, Royal Society report, 2248
curriculum, reform, England, 549
curriculum, reorganized at McGill, 1324
curriculum, two year medical school, [Williamson] 1393—ab; [Upham & others] 1396—ab
entrance requirements, A. M. A. resolution on, 1823; 1904
function of hospital in training of interns and residents, [Curran] ★753
graduate course, Bureau of Medical Relations with Foreign Countries, Paris, 1828
graduate course (compulsory) for Rumanian physicians, 481; 1832
graduate course in obstetrics and pediatrics, federal funds for, Wisconsin, 1827; 2077
graduate course offered by Kellogg Foundation, 1209
graduate, Fellowship of Medicine; Postgraduate Medical Association, 866
graduate institute, Philadelphia County Society, 390; 1322
graduate training of physicians, A. M. A. survey, 1198
history, in United Kingdom, 54
in England, Lord Horder's address, 1906
medical ethics relation to, 1183
New York Hospital and, 384—E
pediatrics in, 397
practical training lacking, Morrisania internship examination, [Van Etten] ★773
premedical, state requirements, ★1484
restricted to those who have money, [Lyon] 1499—ab
supervision by Association of American Medical Colleges, [Rypins] 1395—ab
teaching allergy, [Kern] 1409—C
teaching obstetrics, [Reed] 1204—ab; (discussion) 1205—ab; [Kosmak] ★1435; [Riley] ★1438; [Adair] ★1441
teaching preventive medicine, survey, 2078
teaching psychiatry, conference on, 474; 2014
university responsibility in, [Gilmore] 1206—ab
EDUCATION, MEDICAL—Continued
university (state) and, [Willard] 1098—ab
use of outpatient department in, [Marriott] ★1442
EDWARDSON, OLAF, barber wanted for forgery, 633
EDWENIL, 126—E
EEL, common, 1724—ab
EFFICIENCY of soldiers, effect of coffee, [Voigt] 1136—ab
EFFUSION, Pleural: See Pleura
EGGS, as source of food poisoning, 719
sensitivity to, 2181
White Precipitin Test: See Albumin
EIJKMAN Test: See Bacillus coli
ELASTIC Adhesive: See Skin grafting
ELBOW, drawing-up, in artificial respiration by Schafer method, [Héderer] 341—ab
dislocation, traumatic ossifying myositis after, [Böhler] 2269—ab
traumatic flail, [Murray] ★282
ELBRIDGE REEVES JOHNSON Foundation: See Foundation
ELECTRICITY aids to hearing, 54
Alternans: See Heart
Anesthesia: See Anesthesia
baker, Edmands, 1008
centenary of death of Ampère, 1740
discharge, cataract due to, 66
equipment and explosions in operating room, 134
lesions due to, 1676
static and anesthesia explosions, 933
welding rods (Rego No. 333 A), industrial hazards, 1590
ELECTROCARDIOGRAM: See Heart
ELECTROCOAGULATION: See Diathermy, surgical; Uterus, cervical metritis
ELECTROMYOGRAPHY: See Myotonia
ELECTROSURGERY: See also Diathermy, surgical (cross reference)
Bovie Unit, 707; 1008
ELECTRO-URETHROTOMY: See Prostate, hypertrophy; Urethra strictures
ELEOMAS after injecting camphor in oil, [Repetto] 2203—ab
ELEPHANTIASIS of extremities, [Allen] 157—ab
occurring with varicose veins, [Biegeleisen] 2032—ab
ELLA SACHS PLOTZ Foundation: See Foundation
ELON-HYDROQUINON, sensitivity to photographic solutions, 1028
ELORDA Creams, 1678—BI
ELROY'S Six Point Remedy, 143—BI
EMACIATION: See also Pancreas
hypophyseothyrogenic adiposity and, [Wahlberg] ★1968
EMBALMERS: See under Medicolegal Abstracts at end of letter M
EMBALMING, method of; use of formaldehyde, 867
EMBO: See Anemia, treatment

EMBOLECTOMY, arterial, late results, [Strömbeck] 170—ab
pulmonary, technic, [Nyström] 420—ab
EMBOLISM: See also Thrombosis
air, cause of death in, [Pfanner] 2267—ab
air, complicating pneumothorax therapy, [Cutler] ★1371
air, mechanism, 1410
etiologic factors, 310
mesenteric (superior), [Okunj] 662—ab
of lower extremities, Pavaex for, [Conway] ★1155; [Wilson & Roome] ★1885
paradoxical, [Koritschoner] ★1269
pulmonary, differentiating from coronary thrombosis, [van Bogaert] 661—ab
pulmonary (postoperative), 396
pulmonary, Trendelenburg operation for, [Wustmann] 167—ab
treatment, papaverine [de Takáts] ★1003
unilateral edema, 238
EMBRYO, abnormal shortness of allantoic stalk, [Politzer] 967—ab
EMERGENCY RELIEF, Bureau of New York City, medical care, 304; 1668
digest of laws on, Wisconsin, 1670
rolls, medical service and hospital care for employees on, 1175; 1179
EMERSON Diaphragm Respirator, Infant Model, 1563
EMMENIN: See Estrogenic Substances
EMOTIONS, correlation of psychic and somatic disorders, [Fetterman] ★26
diarrhea and, [Sullivan] 1423—ab
postemotional melanotic pigmentation, [Bonorino Udaondo] 580—ab
Rockefeller Foundation fellowship for study of, 1668
EMPHYSEMA, complicating chronic bronchitis, 317
complicating progressive idiopathic pulmonary fibrosis, [Hampton] 577—ab
heart in, [Kountz] 1229—ab
pulmonary, symptoms; treatment, [Heckscher] 1138—ab
EMPYEMA, 728
parapneumothoracic, treatment, 1022
thoracis acute, Pezzar catheter and irrigation technic, [Bettman] 1420—ab
treatment, air-tight drainage of nontuberculous, [Santillan] 2197—ab
treatment, intrapleural U-V irradiations, [Mistal] 749—ab
treatment, transfusion, [Schlegel] 1238—ab
tuberculous, double thiosulfate of sodium and gold intrapleurally, [Roccas] 423—ab
ENAMEL, Mottled: See Teeth
polishing, industrial hazard in, 1681
ENCEPHALITIS: See also Encephalomyelitis; Polio-encephalitis; under Medicolegal Abstracts at end of letter M
chronic, sodium iodide for, [Olsen] 1616—ab
lead, from use of rice powder, 228
neoarsphenamine, [Cowper] 1426—ab
nonsuppurative, [Shafer] ★699
periaxialis, familial Schilder's disease, [Meyer] 2199—ab
postvaccinal, etiology, [Heerup] 1864—ab
ENCEPHALITIS, EPIDEMIC, acute, summer epidemics in Tokyo, 312; [Hashimoto & others] ★1266
prevention by intranasal instillation of chemicals, [Armstrong] 1424—ab
sequels, drowsiness, stramonium for, [Stott] 500—ab
sequels, obesity, 869
sequels, Parkinson's syndrome, fever therapy, 874
ENCEPHALOGRAPHY: See Brain
ENCEPHALOMYELITIS, acute demyelinizing disseminated, [Ferraro] 1129—ab
ENDAMOEBA histolytica Infestation: See Amebiasis
ENDARTERITIS obliterans: See Thrombo-Angiitis obliterans
syphilitic, pavaex treatment, [Conway] ★1153
ENDOCARDITIS and hyperthyroidism, 485
acute, due to bacillus of Pfeiffer, 2248
bacterial, and cardiac irregularities, [Segal] 1947—ab
rheumatic, [Abt] 329—ab
subacute bacterial, in thyrotoxicosis, [Maher & Sittler] ★1556
subacute infective, signs of, 10—ab
ENDOCERVICITIS: See Uterus, cervix
ENDOCRINE GLANDS: See also Hormones; and under names of specific glands
article on, in *Esquire*—a disclaimer, [Berman] 1754—C
Brussels Medical Convention discusses, 868
convulsive conditions and, [Pigott] 1523—ab
hepatocardiac syndrome, [de Gennes] 1860—ab
influence on epilepsy, [Klessens] 1526—ab
origin of organic processes, 310
principles, nomenclature, Council report, 1808
rôle in pathogenesis of arterial hypertension, 868
Series of Articles on: See Glandular Physiology and Therapy
system, integration, [Langdon-Brown] 579—ab
ENDOCRINE THERAPY: See Dysmenorrhea
ENDOCRINOLOGY, Institute, Moscow, 1833
ENDOMETRIUM, hypoplasia, [Wilson] 1426—ab
ENEMA: See Colon irrigation
ENGINEER: See Railroad
ENGLISH: See British; Royal
Population: See Population
ENSOL, injection effect on Brown-Pearce rabbit epithelioma, [Pommerenke] ★1654
ENURESIS: See Urination, incontinence
ENZYME content of pancreas adenocarcinoma, [Sugiura] 1419—ab
EOSIN Injection: See Knee
EOSINOPHILS, behavior in rheumatic fever, [Friedman] 957—ab
EPHEDRINE, antagonistic to procaine, [Isenberger] 1951—ab
dermatitis of penis, [Hollander] ★706
effect on erythrocytes, leukocytes and platelets, [Simpson] 2196—ab
effect on stomach emptying time, [Van Liere & others] ★535
tend to demobilize glycogen from liver? 730
EPHEDRITONE Inhalant-Massey's, 617
EPIDEMICS: See also Diarrhea; Encephalitis, Epidemic; Meningitis; Scarlet Fever; etc.
news, U. S., 547; 931; 1212
peculiar, in Roskilde in December 1935, [Henningsen] 1342—ab
EPIDIDYMIS, "corpora amylacea" in, [Marsella] 1047—ab
Gonorrhea: See Gonorrhea
tuberculosis, [Herbst] 341—ab
EPILATION: See Hair removal
EPILEPSY: See also under Medicolegal Abstracts at end of letter M
diagnosis (differential), [Moeller] 2203—ab
effect of artificial pneumothorax in, [Slivko] 260—ab
endocrines relation to: before and after puberty, [Klessens] 1526—ab
International League Against Epilepsy, American Branch organized, 1391
possible, in 17 year old boy starting at puberty, 145
seizure, basal joint reflex absent, [Stiefler] 750—ab
seizure, effects of increased oxygen pressure, 2073—E; [Lennox] 2104—ab
seizure, lift reaction as aura, [Hoff] 2269—ab
seizure only after coitus, 486
traumatic, in ex-service men, 934
traumatic (late), [Meyer] 1342—ab
treatment, effect of fluid intake on, 1412
EPINEPHRINE, Ampul Solution Procaine Hydrochloride with, 782
contraindication to use in asthma, 67
disposes to ventricular fibrillation, [Nathanson] 314—C
effect on autonomic nervous system, [Jackson] ★358
effect on blood coagulation, [Simon] 419—ab
effects of long continued use in asthma, 148
fibers of autonomic system which liberate, [Jackson] ★359
tetany in asthmatic after, [Ellsworth & Sherman] ★284
EPITHELIOMA: See also Chorionepithelioma
Brown-Pearce rabbit, effect of injecting bacterial filtrate on, [Pommerenke] ★1654
of skin of bridge of nose, roentgenotherapy cures, [Friedman & Engel] ★1879
EPITHELIUM: See also Urinary Tract
inclusions in female gonorrhea, [Spitzer] 83—ab
EPITUBERCULOSIS: See Tuberculosis, Pulmonary
EPSOTABS, 1837—BI
ERGOAPIOL, 2180
ERGOBASINE, 1008; 1012—E
ERGOMETRINE, 1008; 1012—E
ERGONOVINE, Council adopts name for new ergot alkaloid, 1008; 1012—E; 1807
isolation, 1580; 1748
ERGOSTEROL, Irradiated: See also Viosterol
irradiated (selectively), [Rider & others] ★452
ERGOSTETRINE, 1008; 1012—E
ERGOT: See also Ergotamine
alkaloid (new), Council adopts the name "Ergonovine," 1008; 1012—E; 1807
alkaloid (new) isolated, 1580; 1748
oxytocic principle, [Tuck] 250—ab
ERGOTAMINE Tartrate: See also Migraine, treatment
tartrate, bilateral gangrene of feet from, [Yater & Cahill] ★1625
tartrate, effect on cerebrospinal fluid pressure, [Pool] 954—ab
tartrate (gynergen), gangrene and death from, [Gould & others] ★1631
tartrate, use in various conditions, [Lichtman] 2253—C
toxic action of corn smut used as abortifacient, [Dragisić] 1430—ab
use in scleroderma, 1682
ERGOTOCIN, 1008; 1012—E
ERUPTION: See Exanthem
ERYSIPELAS in infants, x-ray irradiation, [Sonnauer] 1860—ab
mortality, multiple serologic reactions, 1010—E
recurrent, of leg, 1030
treatment, animal charcoal, [Gonzalez] 1430—ab
treatment, hydrochloride of sulfamido-chrysoidine, [Meyer-Heine] 2113—ab
ERYTHEMA annulare rheumaticum, [Abt] 329—ab
ERYTHEMA—Continued
multiforme, diagnosis, 1115
nodosum, tuberculous etiology, [Aguirre] 1429—ab
ERYTHREDEMA: See Acrodynia
ERYTHREMIA: See Polycythemia
ERYTHROCYTES, basophilic stippling, [Rosegger] 1236—ab
basophilic aggregation counts, fluctuations, [Gowen] 2105—ab
content of blood in menstrual cycles, [Leverton & Roberts] ★1459
count, of dog, 402
count, symptomatic erythrocytosis, [Otto] 1771—ab
ephedrine effect on, [Simpson] 2196—ab
factors M and N in, [Blinov] 343—ab
fragility in pneumonia, [Needles] 955—ab
mechanism of postsplenectomy erythrocytoid reequilibrations, [Moore] 325—ab
relation to blood pressure, [Doles] 421—ab
resistance in tuberculosis in children, [Andreucci] 963—ab
Sedimentation: See Blood
stain for stipple cells in lead poisoning (Wright's substituted for Henderson's), [McKinney & Rosenzweig] ★1660
ERYTHROCYTOSIS: See Erythrocytes count
ESCHERICHIA Coli: See Bacillus coli
ESOPHAGITIS; clinical study, [Vinson & Butt] ★994
ESOPHAGUS dilatation (idiopathic), treatment, [Heyrovsky] 2205—ab
erosion (acute), early bougienage justified? [Belinow] 168—ab
foreign bodies, x-ray diagnosis, [Scott & Moore] ★906
ESQUIRE: See Journals
ESTROGENIC SUBSTANCES, abortion and, [Shute] 747—ab
action on blood pressure, [Steinkamm] 1526—ab
clinical use of emmenin, [Goldberg] 573—ab
effect of progynon-B on uterine contractions, [Falls & others] ★271
effect on diabetes, [Collens & others] ★678
in pregnancy urine, detection by paranitroanilinediazonium chloride, [Schmulovitz] 335—ab
lactation ceases after injecting, [Sawizki] 259—ab
menstrual edema controlled by emmenin, [Atkinson & Ivy] ★515
menstruation inhibited by, [Zondek] 2206—ab
ointment for percutaneous administration, [Zondek] 423—ab
pituitary tumors and breast cancer produced by painting skin with, [Cramer] 1768—ab
rôle in tumor formation; advise caution, 1093—E
sarcoma in male mice and, 1990—E
treatment, [Neumann] 1136—ab
treatment of cystic mastopathy, [Dahl-Iversen] 1138—ab
treatment of dysmenorrhea by antuitrin-S, emmenin liquid, progynon and progynon-B, [Israel] ★1698
treatment of gonorrheal vaginitis (injection and suppositories), [Lewis & Adler] ★2054
treatment of hemorrhage with theelin in oil, [de Silva] 957—ab
treatment of irregular uterine bleeding, 2179
treatment of menopause symptoms with amniotin, theelin, etc., 1029; ("splitting" headache) 1592; 2025
treatment of migraine with amniotin, [Soltz] 1232—ab
treatment of pelvic inflammatory disease with amniotin, [Fluhmann] 1426—ab
treatment of Simmonds' disease with progynon-B, [Dunn] 1042—ab
ESTRUS in mice and mammary cancer, [Burns] 951—ab
ETCHING: See Art
ETHANE, hexachlor, toxicity, 484
ETHER diphenyl, in industry, 65
ETHICS, MEDICAL, charges and trials, Judicial Council decision, 1197
discipline of medical profession in England, Lord Horder's address, 1906
hippocratic oath restored in U. of Paris, 550
new law extends professional secrecy, Germany, 867
punishment of professional offenses, Germany, 552
relation to medical economics, 1183
Ross-Loos case, A. M. A. Judicial Council action, 300
scientific discoveries and patents, 1388—E
ETHIOPIA, second British Red Cross unit for Abyssinia, 717
veterinary help for animals in Abyssinia, 1214
ETHOBUTYLETHYLMALONYLUREA: See Anesthesia, barbital compounds
ETHYL Gasoline: See Gasoline
ETHYLENE: See Anesthesia
ETHYLHYDROCUPREINE Therapy: See Asthma
EUGENICS: See also under Medicolegal Abstracts at end of letter M
blondes and, 67
problem, annual Galton lecture, 1325
Society, schedule for voluntary prenuptial examination, England, 1672
Sterilization: See Sterilization, Sexual
EUTHANASIA: See Death

EVANS, GRIFFITH: pioneer of veterinary pathology, death, 392
EVEREADY Professional Carbon Arc Lamp, 1899
EVIDENCE: See under Medicolegal Abstracts at end of letter M
EXANTHEM, rare, in acute polyarthritis, [Van Der Sande] 504—ab
diagnosis of unusual eruptive disorder, 2182
eruptions in lumber workers, 2092
EXERCISE: See also Athletics; Physical Education
blood changes after exertion at high altitudes, [Jezler] 2266—ab
contributory causes of coronary thrombosis, [Phipps] ★761
Passive: See Blood Vessels disease
Therapeutic: See Asthma; Blood Vessels disease; Phlebitis; Thrombo-Angiitis Obliterans
Tolerance Test: See Heart
Underwater: See Paralysis
walking down stairs in heart disease, [Bishop] 401—C
EXERTION: See Exercise
EXHIBIT: See American Medical Association: Art; Books; San Diego; Texas
EXOPHTHALMOS: See also Goiter, Exophthalmic
after thyroid extract, [Brain] 1691—ab
in catarrhal sinus disorder, [Cohen] 1521—ab
mechanism, 1593
EXPECTORANTS, 135; [Fantus] ★375
EXPECTORATION: See Cough; Sputum (cross reference)
EXPLOSIONS: See Anesthesia
EXPOSITION: See San Diego; Texas
EX-SERVICE Men: See Veterans
EXTRASYSTOLES: See Arrhythmia
EXTREMITIES: See also Ankle; Arm; Foot; Legs; etc.
Amputation: See Amputation
Bone Grafts of: See Bones grafts
diseases, gentian violet, phenol and water injected intra-arterially, [Luccarelli] 257—ab
lymphedema, [Allen] 157—ab
pain in limbs after cerebral thrombosis, 1756
pulsation of veins, [Teufl] 2267—ab
spastic lesions, sympathectomy in, [Adson] ★363
vascular changes in, 1592
Vascular Disease: See Blood Vessels disease
EXUDATES, differentiating from transudates, [Fucci] 2113—ab
EYEBROW plucking, fatal streptococcic septicemia from, 54
EYEGLASSES: See Glasses
EYES: See also Blind; Blindness; Cornea; Macula Lutea; Ophthalmology; Orbit; Retina; Vision
Blinking: See Blinking
changes (ophthalmoscopic examination) in hypertensive toxemia of pregnancy, [Hallum] ★1649
diseases, local quinine therapy, [Selinger] 740—ab
enucleation, gold sphere implanted in Tenon's space after, 2181
examination, portable dark room (umbrella with curtains) for, [Olsho] ★115
Hospitals: See Hospitals
pain, use of nupercaine ointment to relieve, [Minnich] 738—ab
symptoms in exophthalmic goiter, pathogenesis, [Spector] 884—ab
Syphilis: See also Nerves, optic
syphilis, Kettering hypertherm therapy for, [Culler] 2104—ab
tattooing, 1116
EYESIGHT: See also Blindness; Vision
swindlers, 711

F

FACE: See also Mouth; Nose
hemiatrophy, [Burket] ★1719
Paralysis: See Paralysis
Ringworm: See Ringworm
surgery (plastic) after being struck in face by board, 1333
FAGISOTE, 64—BI
FALKER-KOOPMAN Test: See Gonorrhea diagnosis
FALLOPIAN TUBES: See also Sterilization, Sexual, tubal
factor in sterility in Chinese women, [King] 2202—ab
roentgen diagnosis for sterility, [Sasaki] 1429—ab
FAMILIES, congenital defects in siblings of first congenitally malformed children, [Murphy] ★457; [Kleindienst] 502—ab
large, special aid for, Germany, 58
mental inferiority of first-born, [Luxenburger] 1773—ab
tuberculosis in, 125—E
FARASTAN or Mono-Iodo-Cinchophen, 1411
FARM Bureau: See American
FASTENER, Slide: See Zipper
FAT: See also Acid, fatty; Lipids; Lipoids; Oil
atrophy after insulin injection, 318; [Dinkler] 1432—ab
in Blood: See Blood
in Feces: See Feces
metabolism and choline, 1201—E
symmetrical, on ankles and legs, 239
FATHER: See Parents; Paternity
FATIGUE, muscle, 563
nervous, colon spasticity and sexual hypersensitiveness, 646
FATTY Degeneration: See Liver
FAULTLESS Brand Tomato Juice; 1166
FECES, blood in, occult hemorrhages, [Häcker] 749—ab
fat in, pathology, [Parmelee] 495—ab
Fistula: See Fistula
incontinence, chronic constipation cause of, [Priesel] 1430—ab
laxation, rôle of indigestible food residues, [Williams] 412—ab
Norgaard's catalase reaction in intestinal disorders, [Kemp] 1955—ab
pink discoloration in infant due to urates in urine, 1938
urobilinogen, determination, technic, [Fleischhacker] 663—ab
urobilinogen values in, [Ehlert] 167—ab
FECUNDATION: See Impregnation
FEDERATION of State Medical Boards (survey of medical schools), [Cutter] 1392—ab; (resolution on broadcasting quackery over radio) 1574
FEDOROV, S. P., death, 1833
FEEBLEMINDEDNESS: See Mental Defectives
FEEDING: See Infants
Gastrostomy: See Stomach surgery
FEES: See also "Compensation of Physicians" under Medicolegal Abstracts at end of letter M
schedule of National Syndicate of Physicians, Italy, 2251
FEET: See Foot
FELLOWSHIP: See also Scholarships
Kellogg Foundation, in public health, 1015
Mickle (Charles) awarded to Dr. Van Slyke, 2013
of Medicine for postgraduate education, 866
research, available at U. of Oklahoma, 389
Rockefeller Foundation, for study of emotions provided by, 1668
FELTON'S Serum: See Pneumonia, treatment
FEMUR, fractures of neck, 137
FENNER'S Golden Relief, 64—BI
FERMENTS, oxidizing: See Catalase; Oxydase; Peroxydase
FERRIC CHLORIDE: See Iron salts
FERROCYANIDE: See Sodium
Excretion Test: See Kidney function test
FERROUS Tartrate: See Anemia, treatment
FERTILIZATION: See Impregnation
FERTILIZER, artificial, occupational diseases from, 237
FETUS: See also Embryo; Infants, New-Born
dead, deformed, macerated, hysterography in diagnosis, [Greenhill] ★606
diabetes in mother; offspring well protected against, 136
dropsy, pathogenesis, [Czyzak] 2116—ab
head, development of deflexion attitudes, [Jungmann] 1615—ab
heart rate, changes, [Sontag] 1848—ab
hematopoiesis in, [Wintrobe] 78—ab
lymphogranuloma inguinale transmitted to, [Dick] 1613—ab
Presentation: See Labor presentation
treatment of intra-uterine asphyxia, [Hecht] 663—ab
viability, diagnostic sign by gentle pressure on head, [Kanter] 234—C
FEVER: See also Rheumatic Fever; Scarlet Fever; Temperature, Body; Typhoid; Undulant Fever; Yellow Fever
Dengue-like: See Dengue
Lemmings: See Lemmings
"milk fever," 942
obscure, diagnosis, [Hamman] 1521—ab
Rat-Bite: See Rat-Bite Fever
skin surface temperature variations during, [Bierman] ★1159
Swamp: See Swamp Fever
syndrome in infants after operation, [Genet] 2266—ab
Therapeutic: See also Encephalitis, Epidemic, sequels; Leprosy; Malaria, therapeutic; Mycosis fungoides; Neurosyphilis; Paralysis, General, of insane; Syphilis
therapeutic, effects on blood count, urine and blood chemistry, [Simon] 1042—ab
therapeutic, Inductotherm, 1091
therapeutic, Kettering hypertherm, [Klauder] ★201; [Simpson] 246—ab; [Desjardins & others] ★690; [Metz] ★1658; [Barnacle & others] ★2046; [Culler] 2104—ab
FIBRIN: See Blood
FIBRINOGEN: See Blood
FIBROIDS: See Uterus
FIBROSIS: See Lungs; Placenta
FIBROSITIS, treatment, oil suspended vaccine, [Scott] 1954—ab
FIELD Mouse: See Mice
FILARIASIS, 404
FILMS: See Motion Pictures
X-ray: See Roentgen Rays
FILTER: See Air
FILTRATE, bacterial: See Bacillus histolyticus
FINGERPRINTS, constitutional mark in mental diseases, [Møller] 344—ab
studies on, 721
FINGERS: See also Nails; Toes
clubbing, (familial and congenital), [Witherspoon] 954—ab
congenital flexion contracture of thumb, [Regele] 1614—ab
FINGERS—Continued
numbness of thumb with paroxysms of pain, 316
tendons damaged, repair, [Mayer] 953—ab
Thumb Reflex: See Reflex
FIRE damp veins, gases that escape from, Belgian mines, 1676
FIRST AID, films for instruction in, 228
for sudden illnesses, Germany, 1215
splints on ambulance, 628—E; 712
treatment of fractures, 628—E
FISCHERQUARTZ Ultraviolet Lamp, Model No. 77, 1806
FISCHERTHERM, 1563
FISH: See also Eel
billion dollar industry, 1882—ab
Liver Oils: See Liver
preservation, carbon dioxide in, 470—E
FISHBEIN, MORRIS, commended, 1917
FISHBERG'S Concentration Test: See Kidney function tests
FISSURE: See Anus; Brain
FISTULA, anal; any new treatment? 1593
fecal; after resection of sigmoid carcinoma with primary anastomoses, 644
tuberculous and osteomyelitic, silver nitrate sticks for, [Freund] ★1268
umbilical, in adult, [Wilmoth] ★526
urinary, operations for, [Martius] 1049—ab
uterine, [Küstner] 503—ab
vesico-intestinal, caused by foreign bodies [Herbst & Miller] ★2125
FLACH Test: See Respiration
FLAIL Elbow: See Elbow
FLASHLIGHT Batteries: See Batteries
FLOOD, emergency program, Ohio, 2013
medical problems created by, 1092—E
stricken town quarantined, Pa., 1102
waters in doctor's offices, Pittsburgh, 1505
FLUORESCEIN in lepra reaction, [Roy] 1768—ab
FLUORIDE, sodium, -sodium bicarbonate mixture, poisoning, [Geiger] 1339—ab
FLUOROSIS, endemic, detection, 630—E
FLUSHES: See Menopause
FLUTTER, Diaphragmatic: See Diaphragm
FOIL: See Tin foil
FOLEY'S Syrup, 782; 923
FOLK, LEVI E., yellow fever volunteer, dies, 634
FONTANELS, ossification in congenital syphilis, [Ugarte] 81—ab
FOOD: See also Diet; Infants, feeding; Meat; Nutrition; Vegetables; Vitamin
A. M. A. resolution pertaining to Pure Food Bill (Copeland), 1173; 1188; 1915; 1918
Allergy: See also Eggs; Milk
allergy, gastro-intestinal, in childhood, [Ott] 2032—ab
allergy, gastro-intestinal, leukopenic index, [Gay] ★969; 1988—E
allergy, synovitis from English walnuts, [Lewin & Taub] ★2144
allergy, thrombocytopenia due to, [Squier] 412—ab
aluminum in, from cooking vessels, 218—E
budget, recommended, Italy, 1405
calories (2,000) per day, 1448—ab
Canned: See also Pineapple juice
Canned Food Handbook, 1565
canned (home) peppers, botulism outbreak in New Jersey, [Caprio] ★687
Committee on Foods: See American Medical Association
cooked and fresh, vitamins A and D in, [Coward] 660—ab
Copeland Bill, 1175; 1179; [Woodward] ★1896; 1902—E
faddist, "Prof." Paul C. Bragg, 1408—BI
fuel values, 1346—ab
human, bones as, 769—ab
Poisoning: See also Botulism; Trichinosis; Tularemia
poisoning, eggs as source of, 719
poisoning from green mold on bread? 2256
poisoning from imported antipasto, 543
poisoning, outbreak due to turkey, 131
preservation of fish, carbon dioxide in, 470—E
preservatives in cream, 481
protective, 393
residues (indigestible), rôle in laxation, [Williams] 412—ab
skin temperature after eating, [Booth] 1763—ab
Therapeutic Use: See Diet, therapeutic (cross reference)
time it remains in stomach, 983—ab
toxic effects of selenium, 926—E
urine a pinkish or red color and, 2092
FOOT: See also Ankle; Extremities; Legs; Toes
clubfoot (congenital); etiology, 308
clubfoot, elastic band treatment, [Brown] 742—ab
drop, Gill bone block operation, [Wheeldon & Clark] ★441
gangrene (bilateral) from ergotamine tartrate, [Yater & Cahill] ★1625
inability to move and loss of sensation, 2090
march, with bone changes, [Maseritz] 656—ab
pustular bacterids, [Andrews] 418—ab
return of function after nerve injury, 2025
tired aching feet, bacteriostatic astringent preparation for, 1682
FOOTBALL injuries, fatal, 223
persistent superficial infection of leg from injury, 647; (reply) [Goeckermann] 1333

FOOTBALL—Continued
players, ankle joint injury in, [Lerch] 583—ab
FORAMEN ovale (patent), paradoxical embolism, [Koritschoner] ★1269
parietal enlarged, heredity occurrence, [Pepper] 1038—ab
FORCEPS, lion-jaw, fulcrum for, [Lusskin] ★918
FOREARM, varicose veins, 318
FOREIGN Graduates: See Graduates
Medical Credentials: See Licensure
FOREIGN BODIES: See also Esophagus; Heart; Intestines
wandering bullet in spinal canal, [Pilcher] 1690—ab
FORMALDEHYDE, use in embalming, 867
FORSSMAN Antibody: See Pneumonia treatment
FORT HAMILTON Brand Tomato Juice, 1387
FOSSA, Intercondyloid: See Knee
FOUNDATION, Air Hygiene, Inc., 474
Commonwealth Fund, (pneumonia study) 221; (annual report) 305
Duke, 930
Dunham, 632
Human Betterment, 1827
Johnson (Elbridge Reeves), 1505
Kellogg (W. K.) (fellowships), 1015; (graduate course) 1209
Marburg Fund at Johns Hopkins, 49
Milbank Fund, director, dies, 1102
Plotz (Ella Sachs) grants, 474
Rockefeller, (influenza virus wanted) 635; (grant to Howard U.) 1207; (fellowship to study emotions) 1668; (gift to Columbia to study poliomyelitis and speech disorders) 1927
FRACTURE: See also Clavicle; Femur; Humerus; Jaw; Patella; etc.
A. M. A. special exhibit on, Kansas City, 1296
Colles': See Radius
compound, artificial gastric juice treatment, [Vanovskiy] 1240—ab
dietary requirements, [Cuthbertson] 1608—ab
fulcrum for bone forceps, [Lusskin] ★918
pathologic, due to malignancies, [Welch] 1953—ab
treatment, diathermy, 2094
treatment, first aid, 628—E; (splints on ambulances) 712
treatment, heat, [Gill] ★40
union, calcifications, 392
union, factors modifying; use of noncorroding pins to aid extension, 485
ununited, massive onlay grafts, [West] 1130—ab
FRAMBESIA, treatment, bismuth salicylate suspended in olive oil, 139
FRAUD: See Instruments, repair man; Salesman, fraudulent
FREDERICQ, Professor, death, 1106
FREEMARTIN and intersexuality, 1333
FREEZING: See Milk, frozen
FREI Test: See Lymphogranuloma inguinale
FRENCH Army: See Army
Congress on Hygiene, annual, 1507
FREUD, SIGMUND, 80th birthday, 1663—E
FRIDERICHSEN-WATERHOUSE Syndrome: See Waterhouse-Friderichsen Syndrome
FRIEDMAN Test: See Uterus hydatiform mole
FRIGIDITY, psychic, 730
FROZEN Milk: See Milk
FRUCTOSURIA: See Urine
FRUIT: See Grapefruit; Pineapple; etc.
FUADIN: See Lymphogranuloma inguinale
FUCHSIN: See Gonorrhea treatment
FUEL value of foodstuffs, 1346—ab
FULCRUM for bone forceps, [Lusskin] ★918
FULLERINE, 1111—BI
FUNGI, direct microscopic examination of skin for, [Swartz] 1039—ab
Extracts: See Mycosis
Infection: See Mycosis
yeastlike, in tuberculous sputums, [Ying] 1524—ab
FURUNCULOSIS, immunity, [Smith] 1857—ab
treatment, staphylococcus formaldehyde-treated toxoid, 138

G

GAG reflex, nervous exaggeration, 1940
GALACTORRHEA: See Lactation
GALACTOSE, cataracts produced by, [Yudkin] 496—ab
GALACTOSURIA: See Urine
GALLBLADDER: See also Bile; Bile Ducts; Biliary Tract
absence, use of choleretic in, 2026
bilirubin concentrations in, [Elton] 952—ab
calculi, genesis (infection; cholesterol), gallstones, [Bockus] 2263—ab
calculi, surgical prognosis, [Wilson & others] ★2209
contraction after transfusion, [Bettman & Tannenbaum] ★1376
digestive hormone of wall, [Pribram] 168—ab
during pregnancy, [Potter] ★1070
Excision: See Gallbladder surgery
inflammation (acute noncalculous), [Wolfson & Rothenberg] ★1978
inflammation and canker sores, 66
inflammation (bacterial), [Aronsohn] 1948—ab
inflammation (chronic), calcium chloride and methenamine for, [Machline] 165—ab
inflammation in Salmonella sulpestifer infection, [Walker] 1765—ab
GALLBLADDER—Continued
inflammation, surgical prognosis, [Wilson & others] ★2209
perforation (acute free), [D'Abreu] 882—ab
perforation with massive intraperitoneal hemorrhage, [Bartlett & Bartlett] ★615
roentgen study, diarrhea after using tetraiodophenolphthalein, 1841
secretion, oleic acid and sodium taurocholate as cholagogue, 487
surgery, bile duct pressure relation to pain after cholecystectomy, [McGowan & others] ★2227; 2242—E
surgery, choledochotomies, results, [Bernhard] 662—ab
surgery, prognosis, [Wilson & others] ★2209
GALL-DUCTS: See Bile Ducts
GALLOIS Test: See Respiration
GALLSTONES: See Gallbladder calculi
GALVANISM, use in urethral stricture, 66
GAMMA Rays: See Radium
GANGLION: See also Gasserian Ganglion
intermediate, 1411
GANGLIONECTOMY, Horner's syndrome after, 1411
in clitoris cancer, [Hausen] 1611—ab
lumbar, in arthritis, [Bothe] 2103—ab
stellate, in traumatic facial paralysis, [Caeiro] 1611—ab
GANGRENE: See also Foot; Skin
after ergotamine tartrate, [Yater & Cahill] ★1625; [Gould & others] ★1631
gas, after hypodermoclysis, [Tenopyr & Shafiroff] ★779
gas, prevention by surgical measures, [Caldwell] 2264—ab
in scarlet fever and diphtheria, [Blumberger] 1430—ab
GARAGE: See Automobile
GARGLES, throat irrigation by, [Kaunitz] 1679—C; [Walker] 2253—C
GARROD, ARCHIBALD, death, 1830
GAS Bacillus: See Bacillus welchii
Bleach: See Chlorine
Embolism: See Embolism, air
Infection: See Gangrene
masks, thirty million, England, 1830
Mine: See Mines
Pneumothorax: See Pneumothorax, Artificial
warfare, defense against air attacks, 140; 933; 1506; 1746; 1830
GASOLINE, contact dermatitis produced at a distance by, [Biederman] ★2236
ethyl or high test, dangers in use, 941; 1409
service station attendants, hazard, 1409
GASSERIAN GANGLION, injection into, [Putnam] 655—ab
GASSING: See Chlorine; Gas warfare
GASTRIC JUICE: See Stomach secretion
GASTRITIS: See Stomach inflammation
GASTRO-ENTERITIS, outbreak, Ohio, 1102
GASTRO-ENTEROLOGY, International Society, A. M. A. representative, 2006
National Society for Advancement (first convention), 1928
Societa italiana di gastro-enterologia, 2019
GASTRO-ENTEROSTOMY, intussusception of jejunum after, [Gottesman] ★1895
GASTRO-INTESTINAL TRACT: See also Intestines; Stomach
absorption, 1028
Allergy: See Food allergy
cancer and tuberculosis in, [Säfwenberg] 968—ab
hemorrhage (occult), [Häcker] 749—ab
hemorrhages; analysis of feces in diagnosis, [Boas] 582—ab
infection in poliomyelitis, [Flexner] 1041—ab
polyps: malignancy incidence, statistics, [Lawrence] 1420—ab
ulcerations, bovine streptococcus causing, [Torrey] 1041—ab
GASTROSCOPE for surgical diathermy of stomach and rectum, [Strauss] ★285
GASTROSTOMY Feeding: See Stomach surgery
GELLHORN Pessaries: See Uterus prolapse
GENITALS: See also Genito-Urinary Tract; Gonads; Penis; Testis; Vagina; Vulva; etc.
enlargement produced by parabiosis, [McCahey] 881—ab
staphylococcic actinophytosis (Botryomycosis, [Berger] 1949—ab
tuberculosis in women, 1021
GENITO-URINARY TRACT, abnormalities (congenital), [Barclay] 579—ab
GENTIAN VIOLET Treatment: See Extremities, diseases
GEOGRAPHY, comparative, of thyrotoxicosis, 216—E
importance of geomedical knowledge, 1106
yellow fever and, 2132—ab
GEORGE V, last illness, 866
GERMAN Army: See Army
Measles: See Rubella
GERMANY, government control of lectures on nutrition, 395
Hitler's persecution of Jews et al. (scholarships for victims, England) 1104; (Academic Assistance Council and its successor) 1104; 1604; 1672; (federal commission to protect German blood) 1214; (English universities decline to attend Heidelberg celebration) 1402; (rules for Jewish and non-Jewish physicians) 1509; 1931; (leasing of pharmacies) 1932
GERMANY—Continued
increase in duty on surgical instruments from, 2163—E
"New German Medicine," 478; 1509; 2081
new state physicians' law, 551
Research on Heredity: See Heredity
GESTATION: See Pregnancy
GHON, ANTON, retirement, 475
GIANT, 25 year old error in measuring, [Humberd] ★1713
GIARDIA: See Lambliasis
Von GIERKE'S DISEASE: See Glycogen
GILL Bone Block Operation: See Foot drop
GINGIVITIS: See Gums
GINSBERG, HYMAN, sentenced, 221
GIPSIES, resemblance to Negroes, 148
GLANDS, Ductless: See Endocrine Glands
GLANDULAR FEVER: See Mononucleosis, infectious
GLANDULAR PHYSIOLOGY AND THERAPY, Council report, 1172; 1807
GLARE, reduction in ophthalmic lenses, 2254
GLASSES for those forced to be recumbent, 71; (adv. page 26, Jan. 11, '36 issue)
reduction of glare in, 2254
GLASSWARE, unsanitary handling in beer gardens, [Benning] 1423—ab
GLAUCOMA, 58
primary, and syphilis, [Beckh] 570—ab
GLIOMA, mesencephalic, [Alpers] 419—ab
treatment, roentgen, [Sachs] 1949—ab
GLOBULIN: See Measles
GLOMANGIOMAS, [Bailey] 250—ab
GLOMERULONEPHRITIS: See Nephritis
GLOMUS tumors, [Bailey] 250—ab
GLOSSODYNIA: See Tongue
GLOVES: See Rubber gloves
GLYCAN Foot Rub, 63—BI
GLYCEMIA: See Blood sugar
GLYCERIN Treatment: See Wounds, infected
GLYCINE: See Acid, aminoacetic (cross reference)
GLYCOGEN, ephedrine tend to demobilize it from liver, 730
functions of liver altered in abdominal syndromes, [Lauro] 1235—ab
storage disease (von Gierke's), [Ellis] 1769—ab; (with amylorrhea) [Naish] 2034—ab
GLYCOSURIA: See also Diabetes Mellitus
blood sugar relation to, 307
caused by antuitrin-S given for undescended testes, [Koplin] ★374; (refutation) [Dorff] 1111—C
in biliary tract disease, [Lande] 332—ab
in coronary thrombosis, [Raab & Rabinowitz] ★1705
GOAT'S Milk: See Anemia; Milk
GOITER: See also Hyperthyroidism
adenomatous (toxic), effect of iodine in, [Jackson & Freeman] ★1261
American Association for the Study of, 2015
in infants and children, cardiac changes, [Viethen] 583—ab
malignant, surgery in, 869
GOITER, EXOPHTHALMIC, anesthesia for thyrocardiacs, [Flaxman] 144—C (reply) [Lahey Clinic] 144—C
aortic valve insufficiency in, [Parade] 82—ab
blood in, tadpole experiment on, [Gyorgy] 2114—ab
cardiovascular state in thyrotoxicosis, [Maher & Sittler] ★1546
exophthalmos in, mechanism, 1593
eye symptoms, pathogenesis, [Spector] 884—ab
geography (comparative) of thyrotoxicosis, 216—E
in pregnancy, [Bustos Morón] 81—ab
surgery, Plummer's iodine treatment before, [Melchior] 2115—ab
treatment, roentgen, [Gunsett] 883—ab
GOLD, colloidal, nostrum: Elorda Creams, 1678—BI
preparations, fatal poisoning, [Fatzer] 1134—ab
salts, relation to leukopenia, [Kracke] 1422—ab
sphere, implantation in Tenon's space, 2181
Treatment: See also Empyema, tuberculous; Lupus erythematosus; Tuberculosis, complications; Tuberculosis, Pulmonary
treatment, pigmentation of skin after, [Cardis] 2203—ab
GOLDEN Crest Brand Oleomargarine, 1987
GONADOTROPIC PRINCIPLES: See also Pituitary, anterior; Pregnancy urine extract
action on acid-base equilibrium disorders, [Bock] 582—ab
function of pituitary in menopause, [Engelhart] 2116—ab
treatment, effect of antuitrin-S on diabetes insipidus patient, [Allen & Stokes] ★780
treatment of acne vulgaris with antuitrin-S, [Lawrence] ★983
treatment of dysmenorrhea with antuitrin-S, [Israel] ★1698
treatment of undescended testis, [Koplin] ★374; [Spence] 962—ab; [Allen & Stokes] ★780; [Dorff] 1111—C; 1507; [Werner & others] ★1541
GONADS, biologic effects of pineal extract (Hanson), [Rowntree & others] ★370
GONIN Procedure: See Retina detachment

GONOCOCCUS, Committee for Survey of Research on, report, 1313—E
Filtrate (Corbus-Ferry): See Gonorrhea diagnosis
GONORRHEA: See also Venereal Disease; under Medicolegal Abstracts at end of letter M
admissions for; rates per population, Massachusetts, [Nelson] ★107
Arthritis: See Arthritis
Bartholin gland abscess; question of carrier, 1593
cause of sterility, 394
chronic; granulations in urethra, 1116
chronic; seasonal recurrence of urethral discharge, 1027
Committee for Survey of Research on Gonococcus and Gonococcal Infections, report, 1313—E
control, U. S. Public Health Service recommendation, [Vonderlehr & others] ★115
diagnosis, 1939
diagnosis, complement fixation test, [Hirshland] 1855—ab
diagnosis, Koopman-Falker complement fixation test, [Koopman] 958—ab
diagnosis, skin reaction to Corbus-Ferry filtrate, 486; (clinical cure) [Corbus] 743—ab
epididymitis, 2025
epithelial inclusions in women, [Spitzer] 83—ab
mask for early syphilis, [Kemp] 954—ab
Ophthalmic: See Ophthalmia
phlebitis after, 647
prostatitis, coitus during, 403
septicemia with recovery, 56
Serodiagnosis: See Gonorrhea diagnosis
treatment, 2179
treatment, basic fuchsin, [Araya] 2036—ab
treatment, Corbus-Ferry filtrate, [Spence] 498—ab
treatment, fever, [Desjardins & others] ★690
treatment of acute gonorrheal urethritis in male and gonorrhea in women, 236
treatment, phenylmercuric nitrate, [Biskind] 340—ab
vaginitis, estrogenic substances for, [Lewis & Adler] ★2054
GORDIUS robustus, human parasitization, [Sayad & others] ★461
GORDON Test: See Lymphogranuloma
Three Sevens (777), 143—BI
GORRIE, JOHN, father of artificial ice industry and air conditioning, 1989—E
GOULD Negative Ion Process, 706
GOUT, crampus neuroses and, [Vogl] 1137—ab
pathogenesis, [Nishnevich] 1050—ab
treatment, cinchophen, [Hench & others] 327—ab
GRADUATE Courses; Education: See Education, Medical
GRADUATES, drug nihilism (practical factor), [David] ★405; [Schwartz] 871—C
examined by licensing boards, ★1476-★1478
foreign, A. M. A. resolution on, 1912; 1921
foreign, examined by state boards in U. S., ★1489-★1491
foreign, internships for, Council on Medical Education and Hospitals ruling, 1031
foreign, licensing, Oregon state board ruling, 1505
of other than approved medical schools registered, ★1485-★1488; 1495—E
GRAFT: See Bones; Ovary; Skin
GRANTS: See American Medical Association; Foundation, Rockefeller; National Research Council
GRANULOCYTOPENIA: See Angina, agranulocytic
GRANULOMA: See also Lymphogranuloma
annulare, [Goodman] 1688—ab
bacillary dysentery relation to, [Felsen] 2191—ab
chronic ulcerating, maggot therapy, [Ayres] 740—ab
coccidioidal, [Jordon] 740—ab
coccidioidal, 11 drugs and vaccine for, [Sox & Dickson] ★777
inguinale, stricture of rectum, 1838
perigenital ulcerous, first case reported in Italy, 140
pyogenicum, genital staphylococcic actinophytosis (Botryomycosis), [Berger] 1949—ab
GRANULOPENIA: See Angina, agranulocytic
GRANULOTHERAPY: See Carbon
GRAPE juice, Solitaire Brand, 1009
GRAPEFRUIT, brands accepted, 43; 293
juice, brands accepted, 215; 383; 923; 1474; 1735
GRAVITY, Specific: See Urine
GRAY'S Syrup, 143—BI
GREASE Paint: See Cosmetics
GREENFIELD, MAYLAR, "Cancer Research Aid Fund," 864
GREENS: See Vegetables
GRIDLEY Ice Cream, 43
GROVE'S Emulsified Nose Drops, 1837—BI
GROWTH: See also Dwarfism; Giant; Infants
delayed, treatment, 2255
effects of pineal extract (Hanson), [Rowntree & others] ★370
GRUSKIN Test: See Pregnancy, diagnosis
GUEMES, LUIS, honored, 1510
GULF COAST Clinical Society organized, 2011
GUMMA: See Osteomyelitis
GUMS, periodontoclasia and gingivitis, [Healy] 2105—ab
GUTTADIAPHOT Method: See Blood
GYNECOLOGY, American Board of, examination results, 2078
chronic mastitis and coincident lesions, [Taylor] 1045—ab
Congress of German Society, 50th convention, 394
National Congress of, A. M. A. resolution on, 1996; 1997
New England Society, 1928
GYNECOMASTIA: See Breast
GYNERGEN: See Ergotamine tartrate
GYPSIES: See Gipsies

H

HAEMOPHILUS pertussis: See Whooping Cough
HAIR: See also Alopecia; Beard; Scalp
Blond: See Blondes
hypertrichosis, treatment, 563
monilethrix, [Larsen] 1774—ab
Oily: See Scalp, oily
pigmentation and copper, 629—E; [Alt] 1220—C
Pulling Out: See Trichotillomania
red haired people, skin infections in, 1756
removal by irradiation, [Epstein] 1427—ab; [Symann] 1526—ab
Schridde's cancer hair, [Frick] 1048—ab
setting for asthmatic child; formula given, 1839
washes, possible reaction from sodium sulfite; tartaric acid, 1224
HALDANE, JOHN SCOTT, death, 1671
HALE'S Pride Brand grapefruit juice; orange juice, 923
HALIBUT LIVER OIL, antioxidants (hydroquinone) as preservatives, Council statement, 1732
Squibb Cod-Halibut Liver Oil, 214
Treatment: See Sinusitis
HAMBURGER Test: See Tuberculin
HAMMER Toe: See Toes
HANDEDNESS: See Left Handedness
HANDICAPPED Children: See Children
physically, WPA bureau for, 1577
HANDS: See also Fingers; Nails; Wrist
injuries (industrial), 1676
pustular bacterids, [Andrews] 418—ab
HANDWRITING speed factor, classify school children by, [Quinan] 419—ab
HANON, J., 1510
HANSON Pineal Extract: See Pineal Gland
HAPPY HOUR Brand Strained Vegetables, 123
HARDENER, Chrom-Alum: See Chromium
HARELIP, hereditary nature, 58
HARRISON NARCOTIC ACT, physicians convicted continue in practice, 1819; 1915; 1916
registration under, 1738—E
HARTMAN'S SOLUTION: See Teeth
HARTMANN'S SOLUTION, use of large volume intravenous injections, [Cutter] ★1250
HARVARD (course in automobile control) 712; (conference of arts and sciences) 1576; (symposium on atmospheric environment) 1670; (participates in tercentenary) 1926
HASH: See Beef
HAWAIIAN Pineapple: See Pineapple
HAY, WILLIAM HOWARD, letter from expatient, 63—BI
HAY FEVER, immunity, serologic evidence, [Cooke] 419—ab
immunization, criticize Collins' use of term, [Bergey] 483—C
pollen filtration, 1940
pollen in Alpena, Mich., (reply) [Durham] 239
pollen filtration, 1940
treatment, ephedrine causes dermatitis of penis, [Hollander] ★706
treatment, injecting specific oils unsuccessful, [Brunsting & Williams] ★1533
treatment, ionization, [Ramirez] ★281; (reply) [Hays] 643—C; [Warwick] 939—C; (with zinc) 1116; [Bernheimer] ★1980
HEAD: See also Brain; Cranium; Hair; Hydrocephalus; Oxycephaly; Scalp
injuries and temporal bone involvement, [Skoog] 1616—ab
injuries, effects of cold applications (ice bag) on, 1113
injuries (industrial), 1675
injuries, management, [Money] 1046—ab
HEADACHE: See also Migraine
carbon monoxide, in garage workers, 1332
due to syphilis, 486
menstruation and, 2091
"splitting" at menopause, use of estrogenic substances in, 1592
treatment, chondroitin, Council report, 293
treatment, colon bacillus vaccine, [Mateer] 570—ab
HEALING: See Spine
HEALTH: See also Hygiene; Mental Hygiene; Sanitation
albums (personal), system, Germany, 1831
American Public Health Association, 1578
Anti-Tobacco; Health Anti-Liquor, 2088—BI
budget, protest curtailment, District of Columbia, 928
Child: See Children
city health contest, winner, 1670
code, advisory board to formulate, U. S., 1929
HEALTH—Continued
department (Baltimore), delinquent patients in venereal disease clinics, [Reinhard & Fales] ★1377
department, (Philadelphia) 546; (Kansas City) 1274
departments merge, Ohio, 2013
education position, examination, New York, City, 304
Examination: See Physical Examination
Insurance: See Insurance
International Pacific Conference (second), 139
Maternal: See Maternal
Mental: See Mental Hygiene
minister of, lawyer appointed, Canada, 931
national, and nutrition, England, 1829
National Health Service, China, 229
of applicants for marriage loans, Germany, 2018
Officers, Conference of State and Territorial, 1323
projects under Social Security Act, (Wisconsin) 1212; (Ohio) 1826; (Texas) 2167
public, administration, Kellogg Foundation fellowships, 1015
public, aspect of teaching obstetrics, Maryland, [Riley] ★1438
public, conferences, Georgia, 1925
public, control of syphilis as next objective, 1390—E
public, education, county medical society leadership in, [Carrington & Kilduffe] ★2098
public, organizations hold joint meeting, Canada, 2015
Remedy Products, 2088—BI
resorts, limiting use of waters at, Academy of Medicine report, 56
service, student, 1182; (survey, California) 1574
services, expenditures by cities for, 1828
state department issues handbook, California, 1319
sunlight and, 2071—E
U. S. Army, annual report, 133
U. S., Department of Health with cabinet officer, 1177; 1180; (A. M. A. resolution on) 1188
U. S. Public Health Service (venereal disease control program) [Vonderlehr & others] ★115; (needs physicians) 391; (annual report) 475; (Surgeon General Cumming retires) 859—E; (examination for appointment) 865; 2167; (personnel changes) 1325; (T. H. Parran, Jr. named Surgeon General) 1401; (office of health education established) 1744
unit (first county, Indiana) 130; (57th full time, Alabama) 387; (Hollywood) 1100; (new, Massachusetts) 1740
work, federal grants approved, 1104
HEARING: See also Deafness
aid, Acousticon, 1007
aid, Radioear, 1805
aid, Western Electric Audiphone, 1386
electrical aids to, 54
hardness of, 560
HEART: See also Arteries, coronary; Cardiovascular System; Pericardium
American Heart Association, 1323
American Heart Journal becomes a monthly, 547
auricle, massive left, [Bishop & Babey] ★462
Auricular Fibrillation: See Auricular Fibrillation
auricular sound (audible) in auricular flutter, [Ludwig] 1612—ab
beat, apex, 1156—ab
beat, systole in pellagra, [Feil] 1229—ab
block, Adams-Stokes, 873
block, Adams-Stokes, epinephrine in, [Nathanson] 314—C
block and pregnancy, [Bernstein] ★532; [Greenhill] 872—C
block (partial), effect of posture, [Alexander] 1229—ab
block, relation to coronary disease, [Salcedo-Salgar] 569—ab
blood clot passing from right to left side, [Koritschoner] ★1269
blood supply (new) developed by operation, [Beck] 75—ab
calcium injections effect on, [Berliner] 654—ab
cavities (right), tumor-thrombus filling, [Woodruff & Levine] ★1544
changes in infants and children with goiter, [Viethen] 583—ab
compression (chronic), pericardiectomy; roentgenkymogram, [Griswold] ★1054
concretio cordis, thoracic duct lymph pressure in, [Blalock] 958—ab
conduction system lesions in rheumatic fever, [Gross] 1037—ab; [Etcheves] 2114—ab
defects (congenital), [Steinberg] 585—ab
Disease: See also Cardiovascular Disease; Endocarditis; Pericarditis
disease, anesthesia for thyrocardiacs, [Flaxman] 144—C; (reply) [Lahey Clinic] 144—C
Disease, Hypertensive: See Blood Pressure, high
disease, increase, Chicago, 928
disease, lectures on cardiology at Royat, 1508
disease, narcosustained therapy in psychosis with, [Magnus] 1602—ab

HEART—Continued
disease (pulmonary, syphilitic, rheumatic, etc.) in thyrotoxicosis, [Maher & Sittler] ★1546
disease, rheumatic, [Werner] 955—ab
disease, surgical risk in, [Hickman] 332—ab
disease, treatment and circulation speed measurement, [Godel] 1341—ab
disease, treatment of syphilis with, 944
disease, value of walking down stairs in, [Bishop] 401—C
disease, velocity of circulation from cubital and dorsal veins, [Bertola] 1692—ab
Dyspnea: See Dyspnea
edema, diuretics in, [Wood] 1689—ab
edema, hypoproteinemia, etc., [Ehrström] 1434—ab
electrical alternans, [Hamburger & others] ★902
Electrocardiogram: See also Heart wound
electrocardiogram, alkalosis and acidosis effect on, [Barker] 324—ab
electrocardiogram, artificial pneumothorax effect on, [Natin] 883—ab
electrocardiogram in pellagra, [Feil] 1229—ab
electrocardiographic studies during anesthesia, [Kurtz & others] ★434; [Reid] 1513—C; (reply) [Raisbeck] 1513—C
electrocardiographic values, transparent ruler for determining, [Wirtschafter] ★1466
electrocardiography, bacterial endocarditis and cardiac irregularities, [Segal] 1947—ab
endocrine hepatocardiac syndrome, [de Gennes] 1860—ab
enlargement, reversible, [Walker] ★1795; [Rosenblatt] 2177—C
Fetal: See Heart rate
foreign body in, child born with, 1105
foreign body, needle in right side, [Nissen] 167—ab
function, standard exercise tolerance test, [Brown] ★355; ★356
in emphysema, [Kountz] 1229—ab
Infarction: See also Heart muscle
infarction, sedimentation time in, [Shookhoff] 1421—ab
injection into (indirect massage) in acute nicotine poisoning, [Franke & Thomas] ★507
insufficiency, biochemical factors of failure, [Herrmann] 2107—ab
insufficiency, congestive failure, motorized oscillating bed for, [Sanders] ★916
insufficiency, creatinuria in decompensation, [Kindler] 1612—ab
insufficiency, failure in hypertension, [Averbuck] 951—ab
insufficiency, George V's last illness, 866
insufficiency, mode of death in coronary thrombosis, [Willius] ★1891; ★1892
insufficiency, right ventricular failure in chronic bronchitis, 317
insufficiency, sickle cell anemia cause of cor pulmonale, [Yater] 1849—ab
insufficiency, treatment of failure, [Warfield] ★892
Massage: See also Heart, injection into
massage to supplement artificial respiration, [Bruns] 884—ab
murmurs, functional, [Bystritskiy] 2206—ab
murmurs, use of oscillographs, 404
muscle disorders, early diagnosis and prognosis, [Leimdörfer] 259—ab
muscle impairment, treatment, [Gotsch] 1613—ab
muscle infarct (acute), cerebral symptoms in, [Kjærgaard] 1957—ab
necrosis, cumulative action of digitalis glucosides, 541—E
output in standing position, [Scott] 2191—ab
pleural conglutination effect on, [Korns] 324—ab
Rate: See also Bradycardia; Tachycardia
rate, fetal, changes, [Sontag] 1848—ab
Rhythm: See also Arrhythmia; Auricular Fibrillation; Auricular Flutter; Heart, ventricular rhythm; Ventricular Fibrillation
rhythm, systolic gallop, [Thompson] 254—ab
sensitivity to tobacco, 943
size as shown in roentgenogram, 227
sound (second), duplication sign of pleuropulmonary cirrhosis, [Mura] 165—ab
surgical operation (first) on, [Cutler] 725—C
Valves: See Aortic Valves
Ventricular Failure: See Heart, insufficiency
Ventricular Fibrillation: See Ventricular Fibrillation
ventricular rhythms (induced), action of drugs, [Nathanson] 324—ab
wound, autotransfusion in, [Watson & Watson] ★520
wound (stab), electrocardiogram in, [Davenport] 420—ab
HEAT: See also Cold; Temperature
Altherm Sinus Pad, 921
Edmands Electric Baker, 1008
in arterial hypertension, 873
lamp, Burdick Radiant, 781
regulation effect on Raynaud's disease, [Pearse] 569—ab
Therapy: See also Diathermy, short wave
therapy, Briggs' Thermo Theraputor, 122
therapy in surgical and orthopedic conditions, [Gill] ★40
HEAVY WATER: See Deuterium
HEIM-BLOCH Treatment: See Verruca
HEINZ Brand Strained, (mixed greens) 1165; (apricots and applesauce) 1474
HELIUM, A. M. A. resolutions on proposed legislation, 1912; 1920
Treatment: See Asthma
HELMETS: See Masks (cross reference)
HEMANGIOMA, hematomyelia secondary to, [Buckley] 1951—ab
of adnexa, 1333
treatment, carbon dioxide snow, 561
HEMATEMESIS, early, in splenomegaly in children, [Smith] 160—ab
from gastroduodenal ulcer, treatment with food, [Meulengracht] 660—ab
HEMATOLOGY: See Blood
HEMATOMYELIA: See Spinal Cord
HEMATOPOIESIS: See Blood formation
HEMATOPORPHYRIA, sensitivity to light, 1756
HEMATURIA, nephritis of children, [Nobécourt] 256—ab
HEMERALOPIA, value of old Chinese remedies, 1108
HEMIATROPHY: See Face
HEMICELLULOSE: See Cellulose
HEMIPLEGIA after artificial pneumothorax, 135
after cerebral hemorrhage, 1412
in trichiniasis, [Merritt & Rosenbaum] ★1646
HEMOCHROMATOSIS and heredity, [Lawrence] 340—ab
HEMOCLASTIC CRISIS, postsplenectomy, [Moore] 325—ab
hemolytic shock after transfusion, 2241—E
HEMOGLOBIN content of blood during menstrual cycles, [Leverton & Roberts] ★1459
of normal children; factors influencing formation, [Ross] 1127—ab
regeneration, iron in whole wheat, [Vahlteich] 1043—ab
HEMOGLOBINURIA, fatal, from quinine in early pregnancy, [Terplan & Javert] ★529
transitory, after exposure to cold, [Salén] 260—ab
HEMOMETERS, gaging, 227
HEMOPHILIA, few cases in women; hereditary transmission, 1592
tonsillectomy in patient with, 66; (reply) [Kugelmass] 404
treatment, blood coagulant extract from placenta, [Eley] 1422—ab
treatment, theelin in oil, [de Silva] 957—ab
HEMOPNEUMOTHORAX, [Korol] 1124—ab
spontaneous, [Jones] 1123—ab
HEMOPTYSIS: See also Tuberculosis, Pulmonary
subacute massive collapse with, 1581
HEMORRHAGE: See also Lungs; Meninges; Purpura haemorrhagica; Retina; Stomach; Uterus; etc.
are "Duret hemorrhages" diapedesis hemorrhages? [Berner] 1864—ab
Intracranial: See Brain hemorrhage
Intraperitoneal: See Abdomen hemorrhage
posthemorrhagic uremia, [Meyler] 968—ab
Subarachnoid: See Meninges hemorrhage
treatment, congo red, [Graves] 2263—ab
treatment in nose and throat operations, [Brown] 2265—ab
treatment, snake venom, [Rosenfeld] 329—ab; 1213
treatment, theelin in oil, [de Silva] 957—ab
treatment, transfusion, [Blumberger] 584—ab
HEMORRHOIDS, treatment, desiccation, [Graham] 573—ab
treatment, injection of sodium morrhuate, etc., 2091
HEMOTHERAPY, autohemotherapy in herpes, 65
autohemotherapy (intramuscular) in cerebral hemorrhage, [Colella] 335—ab; 1412
autohemotherapy to reduce postoperative lung complications, [Kárpáti] 1615—ab
autoserum and autoblood, sensitization of skin to, [Bizzozero] 964—ab
shock therapy by heterogenous blood intravenously, [Ryss] 1694—ab
streptococcic septicemia treated with whole blood injections, [Hendry] 1610—ab
HENDERSON Stain: See Erythrocytes
HENRY Reaction: See Malaria, diagnosis
HEPATITIS: See Liver inflammation
HEPATOCARDIAC Syndrome: See Heart; Liver
HEPATORENAL Syndrome: See Kidney; Liver
HEPTENE, β methyl ζ-methylamino-β-γ-heptene, effect on blood pressure and stomach, [Jackson] ★359
HERB Tea No. 10, 1837—BI
HEREDITY: See also Cancer; Harelip; Hemochromatosis; Legs, malformation; Obesity; Palate, cleft
Bureau of Human Heredity, 2247
marriage of cousins dangerous? 1506
of disease, campaign against, Germany, 57; 136; 308; (Bauer's theory)937; 1582
of inmates of institutions, Germany, 1404
of twinning, 719
sex linked ectodermal dysplasia of anhydrotic type, [Thannhauser] ★908
HERNIA: See also under Medicolegal Abstracts at end of letter M
bilateral scrotal, in twins, 1568—E
inguinal, division of spermatic cord in, [Burdick] 75—ab
nostrum, Stuart's; Plapao Laboratories, Inc., 557—BI
HERNIA—Continued
treatment, injection, [McMillan & Cunningham] ★1791; (solutions for) 1807
HEROES: See also Martyrs
Dr. Geiger and Dr. Meyer ill with psittacosis, 47
HERPES: See also Dermatitis, herpetiformis
chickenpox, and, 564
simplex, 935; [Naegeli] 1613—ab
treatment, autohemotherapy, 65
HERRMANN, GEORGE, work on xanthine and mercurial diuretics, [Decherd] 483—C
HERSHEY'S Chocolate, 215; 383
HERTWIG, RAYMOND, resigns from Committee on Foods, 1187
HETERO-ALLERGY: See Anaphylaxis and Allergy
HETEROPHYIDIASIS, hemorrhage in basal ganglions, [Africa] 1605—ab
HEXACHLORETHANE: See Ethane
HEXANITRATE: See Mannitol
HEYD, CHARLES GORDON, A. M. A. vice president, 1813—E; 1923
HIGH BLOOD PRESSURE: See Blood Pressure
HILL'S Nose Drops, 1111—BI
HINDUS, women and birth control, 636
HIP JOINT: See also Pelvis
dislocation (congenital), 1675
dislocation (congenital), late therapeutic results, [Heyman] ★11
fracture, motorized oscillating bed for, [Sanders] ★916
osteo-arthritis, 137
HIPPOCRATIC oath restored in U. of Paris, 550
HIRSCHSPRUNG'S Disease: See Colon, megacolon
HISTAMINE, detection, 945
hyperergic phenomena and, [Gotsch] 1863—ab
in Blood: See Blood
Injections: See Arthritis; Rheumatism
Test: See Tuberculosis, Pulmonary, diagnosis
HISTIDINE in Urine: See Pregnancy, diagnosis
Treatment: See Peptic Ulcer
HIVES: See Urticaria
HOBBIES: See Physicians, avocations
HODGES Ensemble: See Anesthesia
HODGKIN'S Disease: See Lymphogranuloma
HOGAN Brevatherm Short Wave Diathermy, 42; 1660; 2148
HOLBROOK'S Ka-Kolo, 1837—BI
HOLY WATER Fonts: See Water
HOME BRAND Syrup, 782; 923
HOMEOPATHY, candidates examined by state boards, ★1478
HOMICIDE: See Murder
HOMOGENIZATION: See Infants foods; Milk
HOOS' Protein Milk, 923
HORDER, Lord, guest at Kansas City Session, 296—E; 1013; 1391; 1810—E; 1906
HORMEL Brand Corned Beef Hash, 1474
HORMONES, Sex: See under names of specific factors as Androgens; Corpus Luteum hormone; Estrogenic Substances; Gonadotropic Principles; Testis hormone; etc.
vitamins and, 1748
HORNER'S SYNDROME after freeing pleural adhesions, [Mistal] 1429—ab
after cervical sympathectomy, 2182
after sympathetic ganglionectomy, 1411
HORSEHAIR Worms: See Gordius robustus
HORSES, infectious anemia (swamp fever), 1391—E
Serum: See Anaphylaxis and Allergy, serum; Serum
HOSIERY industry, disease in, 729
HOSPITALS: See also Clinics; under Medicolegal Abstracts at end of letter M
A. M. A. on withdrawal approval from those granting special privileges, 1910
A. M. A. resolution on federal aid to, 1922
A. M. A. resolution on granting approval to hospitals for general internships, 1823
A. M. A. resolution on group hospitalization plans include radiologic service, 2007
A. M. A. resolution on membership in county and state associations for staffs, 1916
A. M. A. resolution on practice of medicine by physicians and not by hospitals, 1822
A. M. A. resolution on state society be notified when approval threatened, 1912; 1921
according to type of service, ★788; ★790; 858—E
ambulance service, ★795
American Memorial, of Rheims enlarged, 934
American, of Paris, report, 1507
Annual Congress on, 399; 1095; 1204; 1316; 1392; 1498; 1569
approved by A. M. A., ★798; 874; 2026
approved, training of interns in syphilology in, [Clarke & Exner] ★767
approving and registering, methods, ★796
authorization of physical examinations, treatment, operations, autopsies, [Woodward] ★33
beds, idle vs. occupied, ★784; (map) ★785; 858—E
bequests and donations, 864; 1323; 2167
Berlin Charité, 225th anniversary, 227
Cancer: See Cancer
Chicago Hospital Council organized, 928
children's, ★793
children's, keeping infectious diseases away from, 718
city, patients in, New York City, 1210
convalescent and rest, ★793
Cook County, statistics, 928

HOSPITALS—Continued
Cook County therapy, [Fantus] (coughs) ★375; (nontuberculous lung abscess by Bettman) ★1728; [Lilienthal] 2253—C; (pruritus by Cornbleet) ★2144
crippled children's New Mexico, WPA funds for constructing, 1101
data for 1934 and 1935, comparison of, ★793
eye, ear, nose and throat, ★792
facilities by states and by control, ★786; ★787; ★789; 858—E
facilities by states and type of service, ★790; ★791
for American Indians, 2078
function in training of interns and residents, [Curran] ★753
general, ★788; ★792; 858—E
general, map showing rates of occupancy, ★785
general, treating tuberculosis in, [Hiebert] 1409—C
governmental, ★784; 786; 858—E
group hospitalization, (Bureau of Medical Economics report) 1182; (Judicial Council report) 1197
group plan, Associated Hospital Service of New York, 1577
growth, 1909 to 1935, ★787; 858—E
HOSPITAL PRACTICE FOR INTERNS, 1171; 1807
Industrial: See Industrial
infants hospitalization, 1507
institutional, ★794
insurance schemes, (Great Britain) [Davison] 1317—ab; [McLester] 1816
Internship: See Internship
isolation, ★793
isolation, opened, Rome, 230
Kansas City, Mo., 1274; 1277; 1278; 1279
libraries, ★795
marine, society favors abolishing, 545
maternity, births in, ★792
maternity, eclamptics wanted at Chicago Lying-In, 2164
Michael Reese, psychiatry department expanded at, 1398
New York, and medical education, 384—E
New York City Department of, 1016
Nurse Training Schools: See Nursing
orthopedic, ★793
Outpatient Department: See Outpatient
pathology departments, ★794
pathology laboratory in, [Karsner] ★1445; (discussion) 1499—ab
prison demolished to make way for, New York City, 222
private, in distress, France, 393
protection from air attacks, 140
Provident (for Negroes), Chicago, 1502
psychiatric, ★792
psychiatric, A. M. A. resolution on survey, 1922; 2002
psychiatric, development of mental hygiene, Netherlands, 2019
psychiatric, Menninger Sanitarium, [Menninger] ★756
psychiatric parole clinic, Michigan, 1015
psychiatric residencies announced at Worcester State Hospital, 130
public, plan to establish, Japan, 311
radiology departments, ★794
registered by A. M. A., ★798
registration refused, ★796
residencies in specialties, 860—E
service, California Medical Association resolution on diagnostic medical service, 1168
service corporations, state legislation, 1177; 1180
service in U. S., annual data, ★783; 858—E
service, Paris, Bureau of Medical Relations with Foreign Countries, 1828
state, Brooklyn, for insane, 131
state, Manteno, Ill., 543
taxation under Social Security Act, 322
training of interns, 860—E
Tuberculosis: See Tuberculosis
United Hospital Fund, New York City, 304
HOUSSAY, B. A., returns, 1510
HOWALD Scholarship: See Scholarships
HOWARD University, Rockefeller grant to, 1207
HUBER, GOTTHELF CARL, memorial volume, 1321
HUGHES, WILLIAM L., memorial, 1100
HUMERUS fracture (supracondylar), use of splints, [Meyerding] ★1139
traumatic flail elbow, [Murray] ★282
HUMIDITY, proper, for offices, 145
HUNT, H. LYONS, International College of Surgeons—why? 2162—E
HUNT, REID, 545; (note of appreciation to, by Council) 1806; 1825
HUTCHINSON-BOECK'S Disease: See Sarcoid
HYDATIDIFORM MOLE: See Uterus
HYDNOCARPATE, Phenylethyl: See Lupus vulgaris
HYDRATED Magnesium Trisilicate: See Peptic Ulcer, treatment
HYDREMIA: See Blood, water content
HYDROCARBONS, visceral tumors induced with, [Ilfeld] 2101—ab
HYDROCELE, treatment, injection of sodium morrhuate, etc.; 2091
treatment; method for relief, [Livermore] 253—ab
HYDROCEPHALUS, in siblings, [Murphy] ★457
HYDROGEN, Heavy Isotope of: See Deuterium
HYDROLOGY: See also Mineral Water
development as branch of medicine, Italy, 1750
research center, Italy, 721
HYDRONEPHROSIS, treatment, plastic operations, [Schaffhauser] 1048—ab
HYDROPNEUMOTHORAX, interlobar, [Wachtel] 258—ab
HYDROQUINONE preservative in halibut liver oil, etc., Council statement, 1732
sensitivity to elon-hydroquinone developer, 1028
*di*HYDROXY-ANTHRANOL: See Ringworm
HYDROXYESTRIN BENZOATE (Progynon-B): See Estrogenic Substances
HYGEIA: See American Medical Association
HYGIENE: See also Air; Health; Mental Hygiene; Sanitation
French Congress on, 1507
Industrial: See Industrial
HYPERADRENALISM: See Adrenals
HYPERCALCEMIA: See Blood calcium
HYPERERGY: See Anaphylaxis and Allergy
HYPERGLYCEMIA: See Blood sugar; Diabetes Mellitus
HYPERHIDROSIS: See Sweating
HYPERLEUKOCYTOSIS: See Leukocytes count
HYPERNEPHROMAS of kidney and liver, [Bull] 1050—ab
HYPEROSTOSIS: See Morgagni's Syndrome
HYPERPARATHYROIDISM: See Parathyroid
HYPERPYREXIA: See Fever, therapeutic; Paralysis, General, of insane
HYPERSALIVATION: See Saliva
HYPERSENSITIVENESS: See under Medicolegal Abstracts at end of letter M
HYPERTHERM, Kettering: See Fever, therapeutic
HYPERTHERMIA: See Fever
HYPERTHYROIDISM: See also Goiter
diagnosis, 2092
diarrhea, [Richieri] 424—ab; 1342—ab
endocarditis and, 485
immunization process in, [Bauer] 967—ab
impedance (or phase) angle test, [Johnston] 247—ab
in pregnancy, [Bustos Morón] 81—ab
iodine, [Jackson & Freeman] ★1261
metabolism increased in, [Andrus] 157—ab
quinine test for, [Bram] 335—ab
treatment, paroxysmal auricular fibrillation after subtotal thyroidectomy, [Boas] ★2238
treatment, radiotherapy, 1581
HYPERTONIC Solution: See Sugar
HYPERTRICHOSIS: See Hair
HYPERTROPHY: See Breast; Heart, enlargement; Muscles; Prostate
HYPERVITAMINOSIS: See Vitamins
HYPNOSIS: See Verruca
HYPNOTICS: See also Sedatives
use and abuse, 137
HYPOCALCEMIA: See Blood calcium
HYPOCHLORHYDRIA: See Stomach acidity
HYPODERMOCLYSIS: See Injection, hypodermic
HYPOGASTRIC PLEXUS, resection for pelvic pain in women, [Kindel] 738—ab
HYPOGLYCEMIA: See Blood sugar
HYPOPARATHYROIDISM: See Parathyroid
HYPOPHOSPHATEMIA: See Blood phosphates
HYPOPHYSIS: See Pituitary
HYPOPITUITARISM: See Pituitary insufficiency
HYPOPLASIA: See Endometrium
HYPOPROTEINEMIA: See Blood proteins
HYPOSENSITIZATION: See Anaphylaxis and Allergy
HYPOTHALAMUS, applied anatomy and physiology, [Vonderahe] 1855—ab
HYPOTHYROIDISM, obesity differentiating from hypopituitary type, 1681
HYPOTONIA: See Muscles tonus; Stomach motility
HYSTERECTOMY: See Uterus excision
HYSTERIA, Congress of Alienists discuss, 935
HYSTEROGRAPHY: See Uterus, roentgen study

I

ICE, artificial, Dr. John Gorrie father of, 1989—E
Bag: See Head injuries; Stomach hemorrhage
Dry: See Carbon Dioxide snow
ICE CREAM, (Gridley) 43; (Melvern) 123
ICTERUS Index: See Blood bilirubin
Neonatorum: See Jaundice of new-born
IDIOCY, mongolian, in colored races, [Gesell] ★1146
IDIOSYNCRASY: See Anaphylaxis and Allergy; under Medicolegal Abstracts at end of letter M
ILEITIS, terminal or regional, [Crohn & Rosenak] ★1; [Rosenblate & others] ★1797
bacillary dysentery relation to, [Felsen] 2191—ab
ILEOCECAL region, unusual inflammatory lesions, [Powers] 1125—ab
Sphincter: See Sphincter Muscles
"ILEOCOLITIS ulcerosa chronica," [Rosenblate & others] ★1797
ILEUS: See Intestines
ILLNESS: See Disease
IMMUNE Globulin: See Measles, prevention therapy (nonspecific), Edwenil, 126—E

IMMUNITY: See also Furunculosis; Poliomyelitis; Tetanus; Tuberculosis; etc.
allergy and tuberculin reaction, 540—E
Peritoneal: See Peritoneum
serologic evidence, [Cooke] 419—ab
IMMUNIZATION: See also Diphtheria; Scarlet Fever; Vaccination; Yellow Fever
against diphtheria, typhoid and smallpox, plans to increase, Tennessee, 132
against typhoid fever, scarlet fever, smallpox and diphtheria, routine, 1331
against typhoid, smallpox, whooping cough, etc., 2255
by Inhalation: See Tuberculosis
criticize S. D. Collins' use of term, [Bergey] 483—C
in hyperthyroidism, [Bauer] 967—ab
IMMUNOTRANSFUSION: See Blood Transfusion
IMPEDANCE Angle Test: See Hyperthyroidism
IMPERIAL Cancer Research Fund, report, 716
IMPLANTATION: See Intestines; Tenon's Space; Ureters
IMPOTENCE, artificial, viability of spermatozoa in cervical canal, [Seymour] ★1728
creatine diagnostic test; androsterone benzoate treatment, [Steinach] 1862—ab
treatment by alcoholization of spermatic artery, [Popow] 748—ab
INCISURA Jugularis: See Jugular Notch
INCLUSION Bodies: See Cells
INCOME Tax: See Tax
INDEX Catalogue, 1736—E
Medicus, 1736—E
of Excursion: See Uterus prolapse
Quarterly Cumulative Index Medicus: See American Medical Association
INDIA: See also Hindus
extension of medical service in, needed, 554
INDIANA UNIVERSITY, new medical school building, 632
INDIANS: See also Hindus
American, hospitals for, 2078
American, tuberculosis sanatorium for, (South Dakota) 50; (Minnesota) 130
INDICAN in Urine: See Urine
INDUCTOTHERM, 1091
INDUSTRIAL: See also Insurance; Workmen's Compensation Acts
accidents, seventh International Congress on Occupational Disease, 1675
air conditions in offices, 145
allergy (so-called latent), [Salén] 260—ab
articular lesions from work with pneumatic tools, [Rostock] 1773—ab
blood picture in x-ray and radium workers, [Kaplan] 1424—ab
carbon monoxide headache in garage workers, 1332
dermatoses; eruption in lumber workers, 2092
dermatoses in wood paper industry, 315
disease, A. M. A. resolution on control of, 1920
disease, artificial fertilizer, 237
disease, asbestosis, [Lanza] ★368
disease, Belgian law on damages for, 1676
disease in acetylene welder of gas pipes, 2090
disease in hosiery industry, 729
disease, increase, Germany, 58
disease, investigation by U. S. Congress, 1176; 1180
disease, obligatory declaration, France, 550
disease, pneumoconiosis, interpreting roentgen shadows, [Sweany] ★1959
disease, sensitivity to photographic solutions, 1028
disease, silicosis an occupational disease? 1672
hazard, angina pectoris in locomotive engineer, 2094
hazard in baking industry (asthma, anemia, itch), 1937
hazard in concrete industry, 2255
hazard in making flashlight batteries, 1591
hazard in polishing chrome plate and enamel compacts, 1681
hazard of chlorine (bleach gas) in paper mill, 2024
hazard of electrical welding rods (Rego No. 333 A), 1590
hazard of tetanus in sewing mattresses, 2183
hazard to gasoline service station attendants, 1409
hazard, "tripoli" as source of silicosis, [McCord] ★913
health propositions, A. M. A. resolution on one basic law governing, 1822
hospitals, ★792
hygiene, instruction in, 935
Hygiene Laboratories of Chrysler Corporation, 545
hygiene, symposium on atmospheric environment by Harvard, 1670
medicine, Central States Society of Industrial Medicine and Surgery, 544
medicine, freedom of choice of physician (Spaulding plan), [Bloom] ★1991
medicine in U. S. Department of Labor, 1176; 1180
plants, regular health examinations in, 227
poisoning, argyria, [Harker] 255—ab
poisoning, arsine, in zinc oxide factories, Netherlands, 2019
poisoning, carbon bisulfide, precautions against, 933

INDUSTRIAL—Continued
poisoning, chlorine gassing, treatment, 1222
poisoning, cotton dyes and polyneuritis, 237
poisoning, cotton dyes in textile industry, 317
poisoning, diphenyl and diphenyloxide, 65
poisoning, hexachlorethane and chlorinated retene, 484
poisoning, lead, 146
poisoning, lead, from theatrical grease paint, [Bartleman] 2199—ab
poisoning, lead, in cigar makers, [Jordans] 968—ab
poisoning, paint, 238
poisoning, radium workers, leukocytes variations in, [Goodfellow] 578—ab
training course for inspectors, Maryland, 1209
Unemployed: See Unemployed
use of casein, 710—E
workmen, nutrition, [McLester] *1866
INFANTILE PARALYSIS: See Poliomyelitis
INFANTILISM, familial, [Chand] 2199—ab
static, in Little's disease, [Flusser] 583—ab
INFANTS: See also Children; Infants, New-Born; under names of specific diseases
blood sugar, hypoglycemia, [Neff] 1604—ab
breast feeding by syphilitic mother, 1515
Emerson Diaphragm Respirator, 1563
Erysipelas in: See Erysipelas
feeding, advertising leaflet "Simplified Infant Feeding," 1474
feeding, treatment of milk allergy (casein), [Schloss & Anderson] 1025—C
feeding, use of frozen milk, 562; (reply) [Emerson] 1940
feeding, vitamin D milk, different varieties, [Jeans] *2066; *2150
foods, homogenization, value, 2025
growth (excessive) in, 1938
hospitalization, 1507
incubator babies at Texas Exposition, 2077
mortality, causes, [Saxl] 583—ab
mortality higher in rural areas, U.S., 1928
mortality, low rate, (Connecticut) 1100; (California) 2073
mortality, lowest on record, England, 1019
muscular hypertrophy causing athletic appearance, [Debré] 495—ab
postoperative dietetic measures, [von György] 82—ab
postoperative, hyperthermic syndrome, [Genet] 2268—ab
premature, deaths of 13 due to asphyxia, [McGrath & Kuder] *889
premature, fate of, 1747
premature, vitamin D milk prevents rickets, [Davidson] 879—ab
welfare, 1507
INFANTS, NEW-BORN: See also Embryo; Fetus
Asphyxia: See Asphyxia
born with foreign body in heart, 1105
cholesterol metabolism in, [Mühlbock] 581—ab
dermatitis, [Carter] 2199—ab
diarrhea epidemic, [Barenberg & others] *1256
gastric ulcer with fatal hemorrhage in, [Kunstadter & Gettelman] *207
icterus index in, [Bonar] 73—ab
injury, prevention; resulting mortality, [Galloway] *505
paralysis (isolated peripheral), [Krafft] 259—ab
paralysis of shoulder, 721
pseudo-icterus, [Pierce] 1856—ab
resuscitation, [McGrath & Kuder] *885
size, dimensions at birth, 401
spastic child, [Brockway] *1635
temporomandibular ankylosis and facial hemiatrophy, [Burket] *1719
thymus syndrome in, [Graham] 1130—ab
INFARCT: See Heart; Intestines; Kidney
INFECTION: See also Sacro-Iliac Joint; Skin; Staphylococcus; Wounds, infected
focal, of Billings, relation to middle ear, 140
Gas: See Bacillus welchii
Listerella n. sp., [Burn] 656—ab
persistent superficial, of leg from football injury, 647; (reply: recommends treatment), [Goeckerman] 1333
protect school children against, 228
treatment, vaccine and serum, limitations, [Wadsworth] 658—ab
INFECTIOUS DISEASES: See also Communicable Diseases; Epidemics; and under names of specific diseases
acute, influence on mycosis fungoides, [Klauder] *201
acute, of childhood, recurrence in, 386—E
control, Castellani in military service in Africa, 936
Hospitals for: See Hospital, isolation
in infants, 1507
keeping them away from children's hospitals, 718
problems created by floods, 1092—E
prophylaxis, France, 2249
treatment of circulatory failure in, [Warfield] *892
INFERTILITY: See Sterility
INFLAMMATION: See also Breast; Gallbladder; etc.
treatment, heat, [Gill] *41
INFLAMMATORY Reaction: See Cancer diagnosis
INFLUENZA bacilli cause of meningitis, [Bender] 2115—ab
bacilli (Pfeiffer) septicemia, 2170
bacillus (Pfeiffer) endocarditis, 2248
clinical experiences: leukocytosis, lung complication, 136
effect on development of tuberculosis, 2251
epidemic, California, 631; 1398
epidemic in Alaska, [Pettit & others] *890
gustatory disorders, [Schwanke] 967—ab
pneumonia (atypical) and, [Cass] 1129—ab
problems created by the floods, 1092—E
virus desired for study by Rockefeller Foundation, 635
virus, Philadelphia and Alaska strains, [Pettit & others] *890
virus, propagation on developing egg, [Burnet] 962—ab
virus, recovery, [Andrewes] 960—ab
virus, studies on, [Dochez] 1852—ab
INFUSION, Intravenous: See Injections
INHALANT: See Ephedritone
INHALATION: See Alcoholism; Anesthesia
Immunization by: See Tuberculosis
INHIBIN (testicle hormone): See Prostate hypertrophy
INJECTIONS: See also under names of specific substances as Alcohol; etc.
apparatus for giving parenteral fluid; directions for making solutions, [Walter] *1982
hypodermic, gas infection after, [Tenopyr & Shafiroff] *779
infusion (continuous), possible dangers, [Orr] 336—ab
Intratracheal: See Tuberculosis, Pulmonary
Intravenous: See also under names of substances as Dextrose
intravenous, large volume, use, [Cutter] *1250
intravenous, of solutions; optimal rate of flow; temperature, 1413
mortality statistics, 1114
subarachnoid, of alcohol, hypotonia and paralysis after, 1115
Treatment: See Hernia; Hydrocele; Sciatica; Varicose Veins
INJURIES: See Head; Spine; Tissue; Trauma; under Medicolegal Abstracts at end of letter M
INQUEST: See Coroners
INSANITY: See also Mental Disease; Psychosis
authorization of physical examinations, [Woodward] *33
manic-depressive, adolescent, 295—E
manic-depressive, hematoporphyrin treatment, [Angus] 1599—ab
treatment, committee to study, Oregon, 2014
INSECT: See Beetle
INSECTICIDES, lead poisoning from sprayed apples, 1589
nicotine, acute poisoning, [Franke & Thomas] *507
INSEMINATION: See Impregnation
INSPIRATION: See Respiration
INSTANT Alberty's Food, 558—BI
INSTITUTE: See also Bunge; Chicago; Education, Medical; Endocrinology; Safety
diagnostic, defined, Germany, 478
for Psychoanalysis, Chicago, 1320; 1664—E
of Bacteriology and Serology, Utrecht, 228
of Clinical Physics, Argentine, 1510
of Medical Science to be established, Australia, 2015
of Traumatic Surgery (correction), 862
on conservation of vision, New York, 1321
INSTITUTION: See also Hospitals
outbreak of epidemic jaundice, [Willett & others] *1644
private, hospitals department to license, New York City, 1741
INSTRUMENTS: See also Needle
clamps for ligating renal pedicle, [Young] *1800
for massage of prostate: Eastman Masseur; Leusman, 874
fulcrum for bone forceps, [Lusskin] *918
repair man, fraudulent, 2015
ruler (transparent celluloid) for determining electrographic values, [Wirtschafter] *1466
surgical, increase in duty on, from Germany, 2163—E
INSULIN, alcohol effect on, in diabetes, 730
antagonized by anterior pituitary and estrogenic substance, [Collens & others] *678
effect on arthritis symptoms and respiratory metabolism, [Bowen] 1233—ab
injections, fat atrophy after, 318; [Dinkler] 1432—ab
pituitary (posterior) and, [Ellsworth] 2197—ab
protamine, [Hagedorn & others] *177; [Root & others] *180; 217—E; [Sprague & others] *1701; [Kerr] 2194—ab
reactivity to, increased under influence of high doses, [Baranov] 1050—ab
Retard: See Insulin protamine
Treatment: See also Diabetes Mellitus, insulin in
treatment of acute recurrent hepatitis, [Polack] 1958—ab
treatment of dysmenorrhea, [Altschul] *1380
treatment of menstrual disorders, [Liegner] 344—ab; [Klaften] 584—ab
treatment of pneumonia, [Sinelnikov] 259—ab
INSURANCE: See also Workmen's Compensation Acts; under Medicolegal Abstracts at end of letter M
INSURANCE—Continued
health, A. M. A. Committee on Legislative Activities report, 1915; 1919
health, American Federation of Labor does not favor, 1915
health, Austria, 1933
health, bill passed, Canada, 1401
health, Federal, 1175; 1179
health, freedom of choice of physician, (Austria) 2172; (Italy) 2251
health, Germany, (reorganization of local krankenkassen) 57; (condition of societies) 868; 2250; (diphtheria mortality) 1674
health, group medical service headed by Dr. Charles Dudley Saul ruled illegal, 1400
health, social background, [Scammon] 1316—ab
health, social scientists in the medical field, 124—E
health, state legislation, 1177; 1180
Hospital: See Hospitals
in tuberculosis, Italy, 1021
laws, prepaid medical service subject to, Pennsylvania, 390
Swiss Physicians' Old Age and Life Insurance Society, 2084
INTEGRATION of the medical profession, 1178; 1180; (Michigan's program) 1576
INTERCONDYLOID Fossa: See Knee
INTERCOURSE, Sexual: See Coitus
INTERMEDIN and light and darkness, [Jores] 502—ab
INTERNAL MEDICINE, American board of, A. M. A. approves formation, 1921
National Congress of, Italy, 639
treatment, diiodotyrosine, [Edelmann] 584—ab
treatment, transfusion, [Blumberger] 584—ab
INTERNATIONAL: See also list of Societies at end of letter S
Association for Preventive Pediatrics (fifth conference), 718
College of Surgeons—why? 2162—E
committee awarding prizes for best works on rheumatism, 1833
Conference on Tuberculosis, 2078
Congress for Experimental Cytology (fourth), 1744
Congress for the Protection of Childhood, 397; 2083
Congress of Physical Medicine (sixth), 1506; 1745; (Horder's address) 1929
Congress of Surgery, 1405
Congress on Blood Transfusion (first), 309
Congress on Light (third), 1325
Congress on Malaria (third), 2078
Congress on Mental Hygiene (second) postponed, 475
Congress on Microbiology (second), 1325
Congress on Occupational Disease (seventh), 1675
Congress on Rheumatism (fifth), 1325
League Against Epilepsy, American Branch organized, 1391
Medical Week in Switzerland, 1748
Pacific Health Conference (second), 139
Research Laboratories, Inc., 233—BI
Society of Gastro-Enterology, A. M. A. representative, 2006
Society of Orthopedic Surgery, 1744
INTERNS, *American Interne*, 931
HOSPITAL PRACTICE FOR INTERNS, 1171; 1807
INTERNSHIP, developments in intern training, *797; 860—E
examination for, at Morrisania show lack of practical training, [Van Etten] *773
for foreign graduates, Council ruling, 1031
hospital function in training interns and residents, [Curran] *753
Hospitals Approved for: See Hospitals, approved
required, for licensure, *1484; 1495—E
training of interns in syphilology, [Clarke & Exner] *767
INTERTRIGO, infectious, [Howles] 954—ab
INTESTINES: See also Cecum; Colon; Gastro-Intestinal Tract; Jejunum; Rectum; etc.
absorption, study of, [Abbott & Miller] *16
activity, posterior pituitary extract effect on, [Melville] *102
Cancer: See Colon cancer
Disease: See Ileitis; Lambliasis
disorders, Norgaard's catalase reaction of feces in, [Kemp] 1955—ab
diverticulum, Meckel's, from base of appendix, [Hadley & Cogswell] *537
effect of liver extract on, in sprue, [Miller] 1849—ab
foreign bodies, vesico-intestinal fistulas from, [Herbst & Miller] *2125
Ileus, blood chlorides in, [Voskresenskiy] 1694—ab
ileus (postpartum adynamic), 2024
ileus (slight) in pregnancy, [Yun] 1859—ab
infarcts, newer aspects, 1830
intubation, technic for collecting pure secretion, use of air-filled rubber balloons, [Abbott & Miller] *16
Intussusception: See Intussusception
mucosa preparation, antianemic action, [Erös] 1614—ab
obstruction due to amebiasis, [Bassler] *1965
obstruction, due to hole in mesentery of ascending colon, [Cullen] *895
obstruction, rôle of ileocecal sphincter, [Sperling] 655—ab

INTESTINES—Continued
paralysis, 225
paralytic ileus in acute appendicitis, treatment, 307
paralytic ileus, treatment, 865
physiology of small, with calcified mesenteric lymph nodes, [Golden] 2031—ab
polyposis (diffuse) of large, [Nyström] 426—ab
resorption, rôle of adrenals, 1749
surgery of large, 2251
surgery (resection), self-performed, [Frost & Guy] ★1708
tobacco smoke effect on, [Simici] 2113—ab
tonus, atony from gastric ulcer, [Melchior] 1433—ab
tuberculosis, pneumoperitoneum in, [Salkin] 2102—ab
tuberculosis, Triboulet reaction positive, [Hallberg] 1050—ab
Ulcers: See Colitis, ulcerative
ureter implantation, [Wright] ★1804
INTRACRANIAL PRESSURE: See also Cerebrospinal Fluid pressure
increased, treatment, [Rosenhagen] 662—ab
INTRADERMAL Test: See Leishmaniasis; Pregnancy diagnosis
INTRAVENOUS Infusion: See Injections
Urography: See Urography
INTRINSIC Factor: See Stomach secretion
INTUBATION: See Intestines; Thorax
INTUSSUSCEPTION, 137
irreducible, [Elliot-Smith] 164—ab
of jejunum after gastro-enterostomy, [Gottesman] ★1895
IODIDES, sensitivity to, use of calcium iodobehenate (Calioben or Sajodin), 239
IODINE: See also Goiter, adenomatous
dangers of self treatment recommended by Brady, 1116
effects of, followed by zinc on tissues, 1594
hyperthyroidism, [Jackson & Freeman] ★1261
in tobacco smoke; effect on thyroid, 2181
requirement of man, 541—E
Test (Schiller's): See Uterus cancer
Treatment: See Goiter, Exophthalmic
IODIZED OIL, fatal iododerma after injecting into lungs, [Goldstein] ★1659
use of lipiodol in bronchographic work, 1412
IODOBISMITOL with Saligenin, 382
IODOCHLORHYDROXYQUINOLINE: See Trichomonas
IODO-CINCHOPHEN: See Cinchophen
IODODERMA, fatal, after injecting iodized oil into lungs, [Goldstein] ★1659
*tetra*IODOPHENOLPHTHALEIN, diarrhea after using, 1841
*di*IODOTYROSINE in internal disorders, [Edelmann] 584—ab
IODOXYQUINOLINE Sulfonic Acid: See Amebiasis, treatment
ION, Gould Negative Ion Process, 706
IONIZATION Treatment: See Hay Fever; Trachoma
IOWA Children: See Vitamin A deficiency
IPRAL-Amidopyrine Tablets, 4.33 grains, 214
Sodium, Capsules, 214
IRIDOCYCLITIS, 58
IRIS, flocculi of, and congenital and familial cysts, [Cowan] 2102—ab
IRON, availability in whole wheat, [Vahlteich] 1043—ab
deficiency in adult, [Haden] ★261
effect on hemoglobin formation, [Vahlteich] 1043—ab; [Ross] 1127—ab
in nutrition, [Widdowson] 2110—ab
metabolism, [Hahn] 653—ab
salts, permanent pigmentation after applying ferric chloride, [Traub & Tennen] ★1711
Treatment: See also under Anemia; Chlorosis
treatment, action, [Witts] 1234—ab
IRRIGATION: See Colon; Empyema
IRRITATION: See Dermatitis, irritant; Jaw
ISHIHARA Plates: See Color Blindness
ISOLATION Hospitals: See Hospitals
ISOPROPYL ALCOHOL, 562
ITALIAN Army: See Army
ITCH: See also Scabies
bakers', 1937
cementer's, 2255
ITCHING: See Pruritus
IVY, Poison: See Rhus

J

JACK SPRAT Brand Tomato Juice, 1166
JADASSOHN, JOSEF, death, 1579; 2172
JAPAN Medical Association report on changes in medical system, Japan, 1217
JAUNDICE, blood in, carbonic anhydrase content, [Hodgson] 1857—ab
chronic, and infantilism, [Chand] 2199—ab
diagnosis, 640
diagnosis, fatal familial icterus gravis or anemia in 8 weeks old child, 1840
epidemic, institutional, possible rôle of Leptospira in holy water fonts, [Willett & others] ★1644
etiology, chiniofon, [Dyckerhoff] 83—ab
etiology, cinchophen poisoning, [Palmer] 327—ab
hemolytic congenital, postsplenectomy erythrocytoid reequilibrations, [Moore] 325—ab
of new-born, cholesterol metabolism, [Mühlbock] 581—ab
JAUNDICE—Continued
of new-born, pseudo-icterus, [Pierce] 1856—ab
pruritus of, gangrene after ergotamine tartrate, [Yater & Cahill] ★1625
vitamin A deficiency and congenital atresia of bile ducts, [Altschule] 573—ab
JAW, ankylosis (congenital bony temporomandibular), [Burket] ★1719
cracking noise in, (reply) [Narat] 318
fracture, 644
osteomyelitis, staphylococcus anatoxin for, 1403
reflex irritation from mandibular joint, [Costen] 251—ab
JEJUNUM, intussusception after gastro-enterostomy, [Gottesman] ★1895
Ulcer: See Peptic Ulcer
JELKE'S Good Luck Brand Evaporated Milk, 539
JENTZER, A., International College of Surgeons—Why? 2162—E
JERUSALEM Medical Center, plans approved, 1744
JEWS, Congress of Jewish Physicians, 932
Hitler's persecution of, (scholarships for victims, England) 1104; (Academic Assistance Council and its successor) 1104; 1604; 1672; (federal commission to protect German blood) 1214; (English universities not to attend Heidelberg celebration) 1402; (rules for Jewish and non-Jewish physicians) 1509; 1931; (schächten banned) 1747; (leasing of pharmacies) 1932
mixed marriages in Germany, 719
JOHNS-BASS Blood Counting Chamber: See Blood counting
JOHNS HOPKINS University, 49; 1670
JOHNSON FOUNDATION: See Foundation
JOHNSON, HERMAN M., memorial, 1101
JOINTS: See also Arthritis; Ankle; Elbow; Knee; Synovitis; Temporomandibular Joint; etc.
adhesions, early oxygen injection to prevent, [Henson] 1340—ab
Basal Joint Reflex: See Reflex
lesions from using pneumatic tools, [Rostock] 1773—ab
Mandibular: See Jaws
JOURNALS: See also Newspaper; Press
American Heart Journal becomes a monthly, 547
American Interne, 931
Archiv für Schiffs- und Tropenhygiene, changed title, 932
Colorado Medicine, copyrighted, 129
Delaware State Medical Journal, copyrighted, 471
Esquire; article on ductless glands, [Berman] 1754—C
Hygeia: See American Medical Association
of the American Medical Association: See American Medical Association
official organs of special organizations detract from A. M. A. special journals, 1168
Quarterly Cumulative Index Medicus: See American Medical Association
JOYZ MATÉ, 63—BI
JUGULAR NOTCH, 1594
JURISPRUDENCE, MEDICAL: See Medical Jurisprudence

K

KAISER Wilhelm Society for Advancement of Science, jubilee, 1020
KAISERAIRE Filter Ventilator, 1731
KALINDERU, centenary, 720
KANSAS CITY Session: See American Medical Association
KAPPELER-ADLER Test: See Pregnancy, diagnosis
KATECHIN, Blum's: See Thyroid, antithyroid substance
KATRO-LEK, 64—BI
KAUFFMANN'S Reaction: See Cancer diagnosis
KEEP, NATHAN COOLEY, portrait, 1825
KELLER, WILLIAM L., bust installed, 133
KELLOGG Foundation: See Foundation
KELLY, HARRY EUGENE, memorial, 472
KERATITIS, superficial, and vitamin A, [Stocker] 2113—ab
phlyctenular, etiology, 2248
KEROSENE, deodorized; where obtainable, 2256
KETCHEN, A. D., death, 1406
KETENE for detoxifying vaccine, [Tamura] 959—ab
KETTERING Hypertherm: See Fever, therapeutic
KIDNEYS: See also Urinary Tract
Abscess: See also Abscess, pararenal; Abscess, perinephric
abscess, coccic infections, [Beer] ★1063
amyloidosis, [Altnow] 159—ab; (etiology) [Elkund] 955—ab
anomalies, ectopic, [Thomas] ★197; [Stevens] 1128—ab
anomalies, in children, surgery for, [Campbell] ★194
anomalies, rôle in causing surgical conditions, [Gutierrez] ★183
calculi, [Higgins] 253—ab
calculi, hypothesis for origin, [Randall] 1339—ab
calculi, oxalic acid elimination in, [Herkel] 1772—ab
KIDNEYS—Continued
cancer (hornified squamous epithelial), [Freudenthal] 344—ab
cancer (hypernephroid), [Woodruff & Levine] ★1544
cancer, prognosis, clinicopathologic data, [Braasch & Griffin] ★1343
carbuncle, coccic infections of cortex, [Beer] ★1063
changes in pregnancy, [Hundley] 249—ab
cyst (polycystic), new surgical technic, [Goldstein] 576—ab
cyst (polycystic) with bilateral perinephric abscesses, [Twinem] ★206
degeneration from camphor, 1750
Disease: See also Nephritis; Pyelitis; Pyelonephritis
disease, acacia for edema, [Hartmann] 416—ab
disease, after-history of lipoid nephrosis, [Major] 653—ab
disease, blood sugar increase, [Oefelein] 1862—ab
disease, lipoid nephrosis in child, 225
disease, sulfatemia in, [Øligaard] 2116—ab
disorders complicating syphilis, treatment, 729
disorders (severe), pulmonary edema in, [Klima] 1137—ab
function in ureter obstruction, [Wilcox] 330—ab
function tests, evaluation according to time consumed, [Chapman] 559—C
function tests, ferrocyanide excretion, [Gordon 415—ab
function tests (Fishberg concentration, Mosenthal concentration, urea clearance and sodium ferrocyanide test of glomerular efficiency); technic, 484
Glomeruli: See Nephritis, glomerulonephritis
horseshoe, syndrome, [Gutierrez] ★186; ★187; [Campbell] ★194
impairment in malignant diphtheria, [Brugsch] 1772—ab
infarcts (hemoglobinuric) [Terplan & Javert] ★529
injuries by blunt objects or trauma, 1933
insufficiency developing with use of alkalis, [Steele] ★2049
-liver syndrome, [Helwig] 958—ab; [Faltitschek] 1693—ab; [Boyce] 1766—ab
necrosis (bilateral cortical), in pregnancy, [De Navasquez] 339—ab
pelvis, danger of argyria after silver nitrate lavage, 1413
pelvis, surgery; heminephrectomy, [Abrahsen] 2036—ab
potassium salts excretion by, [Keith] 415—ab
reserve (low), [Peckham] 953—ab
roentgen irradiation in mercury bichloride poisoning, [Balázs] 751—ab
rupture after pyelography, [Baretz] ★980
Surgery: See also Hydronephrosis
surgery, clamps for ligature of pedicle, [Young] ★1800
tumor, hypernephroma, [Bull] 1050—ab
KING GEORGE: See George V
KISSING, tuberculous chancre transmitted by, [Sulzberger] 314—C
KNEE: See also Meniscus; Patella
abnormality, [Vajano] 661—ab
dislocations (complete external lateral); brace used, [Conwell & Alldredge] ★1252; (reply) [Fichman] 1679—C
eosin injection into; value in arthroscopy, [Burman] 1601—ab
intercondyloid fossa, [Danelius] 337—ab
internal lesions, 721
osteo-arthritis, 137
KNOPPIE-SPIDER: See Spider bite
KOCH Cancer Foundation; loses malpractice suit, 929
KÖHLER-PELLEGRINI-STIEDA DISEASE, [Pytel] 1615—ab
KONSULOFF Test: See Pregnancy, diagnosis
KOOPMAN-FALKER Test: See Gonorrhea diagnosis
KOPPERS Stores Brand Evaporated Milk, 617
KOSHER Meat: See Meat
KRANKENKASSEN: See Insurance, health
KRANTZ, JOHN C., Jr., statement on trichloroethylene in angina pectoris, 485
KRAUROSIS vulvae, [Hunt] 1857—ab
KRAUS, FRIEDRICH, death, 1579; 1832
KRAUS, R., honored, 1510
KREMOLA Skin Bleach, 1111—BI
KRIM-KO Chocolate Flavored Drink, 123; 215
KÜSTNER-PRAUSNITZ Reaction: See Pollen extract
K-W Syrup of Tar and Horehound Compound, 143—BI
KYMOGRAM, X-ray: See Heart

L

LABELING: See also Liver preparations
of products subject to deterioration, Council report, 1807
package and advertising, Committee on Foods rules, 1187
LABOR: See also Abortion; Midwives; Obstetrics; Puerperium
Anesthesia in: See Anesthesia
development of deflexion attitudes, [Jungmann] 1615—ab

LABOR—Continued
effect of salt-deficient diet, [Lambert] 83—ab; [Karpati] 84—ab
induction, persistence of quinine effect, 1681
menarche, constitution and, [Weysser] 1957—ab
menstrual cycle and date of birth, [Wahl] 1432—ab
normal, intra-abdominal hemorrhages after, [Küstner] 503—ab
oxytocic principle of ergot, [Tuck] 250—ab
pains, intra-uterine pressure during, 1514
pelvis (contracted), bone graft to increase diameter, 2017
pelvis shape relation to, [Pettit] 960—ab
perineum laceration, sutures inserted before, 2094
postpartum adynamic ileus, 2024
presentation, breech, diagnostic sign, [Kanter] 234—C
presentation, breech, relation to birth injury, [Galloway] ★507
presentation, breech, risk to infant in, [Goethals] 1606—ab
pressor and oxytocic fractions of posterior pituitary extract, [Melville] ★102
relation to cervical cancer, [Tompkins] 249—ab
Third Stage: See Placenta, expulsion
LABORATORY, Air Corps: See Aviation
clinical, licensing, 1180
Connaught (western division) at Vancouver, 391
Industrial Hygiene, of Chrysler Corporation, 545
International Research Laboratories, Inc., 233—BI
of pathology in small hospital, [Karsner] ★1445; (discussion) 1499—ab
personnel, yellow fever in, 890—ab
Plapao Laboratories, Inc., 557—BI
state, limits free work, W. Va., 547
technicians, clinical, schools for, standards proposed by A. M. A., 1820; 1904
LACTATION: See also Milk, human
action of antithyroid protective substances on, [Schumacher] 168—ab
ceases after injecting estrogenic substances and pregnancy urine extract, [Sawizki] 259—ab
galactorrhea, 561
lactogenic substance in human breast, use, [Geschickter] 1851—ab
nursing by syphilitic mother, 1515
LACTOBACILLUS Acidophilus: See Bacillus
LACTOGENIC Hormone: See Lactation
LACTOSE, cataracts produced by, [Yudkin] 496—ab
in milk, relation to blood sugar, [Tolstoi] 78—ab; 469—E
LAKESIDE Laboratories, Inc., Ampoule Calcium Chloride 10%, 1008
LAMBERT'S Rheumatic Powders, 1111—BI
LAMBLIASIS, intestinal giardia, toxicity of carbarsone, [Epstein] ★769
LAMINECTOMY: See Spine surgery
LAMP: See Heat; Ultraviolet Rays
LANDON, ALFRED M., opposes regimentation of medical profession, 1810—E
LANDRY'S Paralysis: See Paralysis
LAROSTIDIN 'Roche,' 1473
treatment of gastro duodenal ulcer, [Sandweiss] ★1452; [Martin] ★1468
LARYNGITIS: See also Laryngotracheitis
epidemic streptococcic, 1332
Tuberculous: See Larynx tuberculosis
LARYNGOTRACHEITIS (acute) in children, [Smith] 2193—ab
LARYNX: See also Vocal Cords
tuberculosis, dysphagia in, electrical anesthesia for, [Grain] 2112—ab
tuberculosis requiring tracheotomy, [Myerson] 1040—ab
ulcer (contact), [Woodruff] ★1562
web in, treatment, [Iglauer] 251—ab
LASKI, HAROLD J., reply to, [Shurly & Bullock] ★297
de la TORRE, FRANCISCO, death, 1510
LATRODECTUS MACTANS: See Spider
LAURENCE-MOON-BIEDL syndrome, [Molitch] 573—ab
LAWS: See Harrison Narcotic Acts; Legislation; Medical Practice Acts; Narcotics; etc.
LAX-AID, 143—BI
LAXATION: See Feces
LEAD, dangers in use of ethyl or high test gasoline, 941
encephalitis from rice powder, 228
poisoning, 146
poisoning and porphyrin in urine, [Franke & Litzner] 585—ab; [Roth] 585—ab; [Carrié] 1237—ab
poisoning, Belgian law grants compensation, 1676
poisoning from casual contact with tetraethyl lead in gasoline, 1409
poisoning from paint, 238
poisoning from theatrical grease paint, [Bartleman] 2199—ab
poisoning hazard from metal foil on chocolate, 1590; (also tobacco), [Williams] 2178—C
poisoning in cigar makers, [Jordans] 968—ab
poisoning, modified stain for stipple cells, [McKinney & Rosenzweig] ★1660
poisoning, possibility from sprayed apples, 1589
LEAGUE OF NATIONS, (commission on nutrition) 306; (statistics on radiotherapy of uterine cancer) 1235—ab; (report on narcotic traffic) 1930
LEATHER, dermatitis from wrist watch straps, 1738—E
LECITHIN, vegetable, Margo CCB, 383
LEFT-HANDEDNESS, stammering and blinking, 1681
LEGISLATION: See also Advertising; Narcotics; Social Security Act
A. M. A. Board of Trustees report, 860
Copeland Food, Drugs, Therapeutic Device and Cosmetic Bill, 1175; 1179; [Woodward] ★1896; 1902—E
cosmetic law upheld by Federal District Court, Maine, 1209
federal, A. M. A. Bureau of Legal Medicine and Legislation report, 1175
for preventing hereditary disease, Germany, 136
medical bills in U. S. Congress, 220; 223; 302; 305; 387; 391; 471; 474; 547; 631; 635; 711; 715; 864; 928; 931 1014; 1018; 1103; 1208; 1212; 1324; 1401; 1502; 1505; 1578; 1666; 1670; 1743; 1824; 1828; 1929; 2015; 2074; 2077; 2167
new law extends professional secrecy, Germany, 867
new state physicians' law, Germany, 551
venereal disease law, violations, Germany, 1215
LEGS: See also Ankles; Extremities; Foot; Knee; Toes; etc.
erysipelas (recurrent), 1030
malformations of right leg, inheritance, 67
nervous sensation in, in anemia, 944
Paralyzed: See Paralysis
symmetrical fat on, 239
LEISHMANIASIS americana of skin, sodium arsenite for, 1583
cutaneous, diagnosis by intradermal test, 2020
LEMMINGS, disease of, [Sylvest] 2206—ab
LEMOS MONTEIRO, typhus martyr, 310
LENSES, Ophthalmic: See Glasses
LEONTIASIS ossea, relation to hereditary syphilis, [Scharff] 1773—ab
LEPEL Diathermy Machine, 921
LEPROSY center (new), South America, 1214
complications, atrophic dermatitis, [Pardo-Castello] 740—ab
increase in beds for, Japan, 1217
international type classification, [Germond] 1691—ab
reaction, fluorescein, [Roy] 1768—ab
treatment, aniline dyes (brilliant green or methylene blue) [Rosental] 752—ab
treatment, induced fevers, [Nocht] 499—ab
treatment, methods, used in Austral Pacific Zone, 139
treatment, vaccine, [Sézary] 501—ab
LEPTOMENINGES: See Meninges
LEPTOSPIRA ictohaemorrhagiae: See Jaundice
LERICHE, RENÉ, lecturer at Collège de France, 1508
LEUKEMIA: See also Cryptoleukemia
[Krumbhaar] ★287; [Wiseman & others] ★613
aleukemic myelosis with cutaneous nodules, [Zimmerman] 2032—ab
course; treatment, [Craver] 952—ab
infiltrations, [Cleland] 961—ab
laboratory observations, [Kracke] 2261—ab
myeloid, vitamin C effect on blood picture, [Eufinger] 1236—ab
thrombocytosis with, [Drake] ★1005 [Kugelmass] 1588—C; (polycythemia?) [Dameshek] 1837—C
LEUKOCYTES, Concentrate Treatment: See Arthritis, atrophic
count, abnormal; technic suggested, 1756
count (Arneth) in asthma treated with autovaccine, [Napier] 2200—ab
count (filament nonfilament) after coronary occlusion, [Goodrich] 326—ab
count (filament-nonfilament) in arthritis and osteo-arthritis, [Hartung & others] ★1448
count, hyperleukocytosis, granulotherapy, [Lumière] 256—ab
count in arsenic treatment, [Halter] 966—ab
count, leukocytosis in influenza, 136
count, leukocytosis (postanesthetic), [Boyd] 1127—ab
count, leukopenic index and food allergy, 1988—E
count, leukopenic index in asthma, [Zeller] 956—ab
count, leukopenic index in peptic ulcer, [Gay] ★969
count, monocyte-lymphocyte ratio in tuberculosis, [Bresci] 2266—ab
count, normal range, 1315—E
count, of dog, 402
count, seasonal variations in acute leukosis, [Engelbreth-Holm] 344—ab
ephedrine effect on, [Simpson] 2196—ab
picture in Hodgkin's disease, [Roth] 2193—ab
variations in radium workers, [Goodfellow] 578—ab
LEUKOCYTOSIS: See Leukocytes count
LEUKODERMA: See Vitiligo
LEUKOPENIA, Toxic: See Angina, agranulocytic
treatment, with pentnucleotide, omnaden, milk proteins and other foreign proteins, 316
LEUKOPENIC Index: See Leukocytes count
LEUKOPLAKIA vulvae, [Hunt] 1857—ab
LEUKORRHEA, morbid alternations in, [Araya] 81—ab
offensive discharge, 1031
trichomonas cause of, 1412
LEUKOSARCOMA and lymphosarcoma, [Krumbhaar] ★288
LEUKOSIS: See Leukocytes, count
LEUSMAN: See Prostate massage
LEVULOSE in Urine: See Urine, fructosuria
LIBERTIES, 143—BI
LIBIDO, at menopause; use of estrogenic substance, 1029
in tuberculous, [Barglowski] 1861—ab
LIBMAN-SACKS SYNDROME, [Belote] 2031—ab
LIBRARY: See also Books; Journals
Abt (Isaac A.) donates to Northwestern, 632
Army Medical, 53; 1736—E
patients', in hospitals, ★795
LICENSURE: See also State Board; State Board Reports
A. M. A. Annual Congress on, 299; 1095; 1204; 1316; 1392; 1498; 1569
consistency vs. chaos in, [Bierring] 1097—ab
diplomas lost, (Dr. Herskowitz) 1400; (Dr. Pangman) 1504
diplomas to be revised, France, 393
foreign credentials, [Pinkham] 1571—ab
foreign graduates, ★1489-★1491; (Oregon adopts regulations) 1505
graduates of other than approved schools registered, ★1485-★1488
internship required for, ★1484; 1495—E
introducing psychiatry in, [Ebaugh] 1571—ab
licenses of Drs. Edward and Wagner lost, 864
narcotic legislation and, [Woodward] 1569—ab; [McIntyre] 1572—ab
registration by reciprocity and endorsement, ★1479; ★1480-★1482
registration, 1904-1935, ★1485
results of government examinations, Italy, 721
statistics for 1935, ★1475; 1495—E
LICHEN planus of vulva, [Hunt] 1857—ab
LICHENOID: See Dermatitis
LIFE Duration: See Old Age; Tubercle Bacillus
Exhibit of Life, 390
expectancy in chronic arthritis, [Nissen] 420—ab
expectancy in coronary thrombosis, [Willius] ★1890
Haldane's philosophy of, 1671
Insurance: See under Insurance
"Longer Life Week," Louisiana, 1926
LIFT Reaction: See Epilepsy
LIGAMENTUM flavum, compression of cauda equina by, [Abbott] ★2129
LIGATURE: See Arteries, hepatic; Kidney
LIGHT: See also Sunlight
artificial, use in visual tests, 2093
daylight in buildings, 126—E
International Congress of (third), 1325
pituitary hormone content and, [Jores] 502—ab
LIGHTNING-LAX, 1111—BI
LIGNIN, rôle in laxation, [Williams] 412—ab
LIMBER NECK in chickens, 1027; (reply) [Murray] 1682
LIMBS: See Extremities
LINIMENT, rubbing, value of mezereum, 1514
LINSEED OIL, severe attacks of asthma after, [McClendon] 64—C; (reply) [Taub & Zakon] 642—C
LIP STICK dermatitis; methyl heptine carbonate, 470—E; [Landsteiner & Jacobs] 1112—C
LIPASE, digestive hormone of gallbladder wall, [Pribram] 168—ab
Injections: See Liver cirrhosis
LIPIDS: See also Fat
in Nerves: See Nerves
reaction of connective tissues to, [Tompkins] 953—ab
LIPIODOL: See Iodized Oil
LIPOIDOSIS, metabolism in, [Raeder] 1240—ab
LIPOIDS in Blood: See Blood
myelins in sputum, [Risi] 169—ab
necrosis (subcutaneous) after camphor oil injection, [Repetto] 2203—ab
Nephrosis: See Kidney disease
LIPOMATOMA, multiple symmetrical, [Miller] ★2059
LIPOVACCINE: See Fibrositis, treatment
LIPS: See Harelip.
LISTERELLA, new species, [Burn] 656—ab
LITTLE'S Disease: See Paralysis, spastic
LITTLE Elf Brand Strained Vegetables, 123
LIVE-ON Tonic, 1837—BI
LIVER: See also under Medicolegal Abstracts at end of letter M
acute yellow atrophy caused by typhoid, [Beumer] 258—ab
Autolyzed Concentrate: See Anemia, Pernicious, treatment
cancer (primary) in child, 135
cells, effects of diathermy on, in pernicious anemia, 1591
chiniofon impairs, [Dyckerhoff] 83—ab
choline and fat metabolism, 1201—E
cinchophen effect on, [Hench & others] 327—ab
cirrhosis, inborn and familial tendency, [Weber] 1859—ab; [Chand] 2199—ab
cirrhosis, lipase injections in, 55
damage and hyperglycemia, 1592
deaths, [Boyce] 1766—ab
degeneration (acute fatty) after carbarsone [Epstein] ★769

LIVER—Continued
degeneration after camphor, 1750
degeneration (fatty) from cholesterol excess, [Beumer] 258—ab
disease, fibrin in blood plasma, [Geill] 504—ab
disease, relation to anemia, [Wintrobe] 1231—ab
disease, spontaneous diuresis in, [Jones] 78—ab
disease, terminal stages in, [Ehrström] 664—ab
disease, water tolerance test in urobilinuria after, [Adlercreutz] 1694—ab
endocrine hepatocardiac syndrome, [de Gennes] 1860—ab
enlargement in diabetes, [Hanssen] ★914
extract, effect in amebiasis, 1094—E
extract, effect on intestine in sprue, [Miller] 1849—ab
extract, 1 cc. Concentrated Solution Parenteral-Lederle, (correction) 122
extract, Solution-Valentine, 1661
extract treatment of nonurate azotemia, [Nonnenbruch] 580—ab
Fatty Degeneration: See Liver, degeneration
fish liver oil preparations, antioxidants as preservatives, Council statement, 1732
function test, galactosuria in pneumonia, [Canali] 1135—ab
function test, sodium benzoate tolerance, [Adlersberg] 1432—ab
function test, Takata-Ara, [Magath] 1338—ab
glycogen, ephedrine tend to demobilize? 730
glycogenic functions altered in abdominal syndromes, [Lauro] 1235—ab
inflammation (acute recurrent): dextrose-insulin hepatargy therapy, [Polack] 1958—ab
Injections: See Acanthosis
insufficiency, alterations in serum proteins as index of liver failure (Takata reaction), [Foley & others] 245—ab
kidney syndrome, [Helwig] 958—ab; [Faltitschek] 1693—ab; [Boyce] 1766—ab
oxalic acid metabolism relation to, [Pennetti] 1611—ab
pregnancy and, 394
Preparations: See also Liver extract
preparations, Council report, 1807
preparations, potency, of Council accepted, 1314—E; (reply) [Murphy] 2089—C
preparations, standardization, labeling, 1172
regeneration and carbon tetrachloride cirrhosis, [Cameron] 1427—ab
rhythmic function, [Jores] 585—ab
rupture, birth injury, [Galloway] ★507
spleen syndromes in undulant fever, [Diehl] 342—ab
thorotrast effect on, [Rigler] 336—ab
tissue after ligating hepatic artery, [Loeffler] 2194—ab
Treatment: See Anemia, Pernicious; Angina, agranulocytic; Liver extract; Liver preparations; Polycythemia
tumor, hypernephroma, [Bull] 1050—ab
LOANS: See Marriage
LOBSTERS, Advertising Booklet for Ocean Clear, 1009
LOCOMOTIVE Engineer: See Railroad
LOEFLUND'S Malt Soup Stock, 1166
LOESER LABORATORIES, criticism of A. M. A. Council by Medical Society of New Jersey, 1173; 1188; 1918
LONG, CRAWFORD W., statue unveiled, 1502
LONGEVITY: See Old Age
LOOS, H. CLIFFORD, A. M. A. Judicial Council action in Ross-Leos case, 300
LOVETT Tuberculin Test: See Tuberculin
LUDEN'S Antiseptic Cough Drops, 143—BI
LUMBER: See Wood
LUMINAL: See Phenobarbital
LUNGS: See also Pleura
Abscess: See also Lungs suppuration
abscess, bronchoscopic studies, [Goldman] 2193—ab
abscess complicating dinitrophenol poisoning, [Imerman & Imerman] ★1085
abscess in childhood, [Priesel] 1860—ab
abscess (nontuberculous), therapy at Cook County, [Fantus] ★1728; [Lilienthal] 2253—C
abscess, short wave therapy, [Schliephake] 1956—ab
abscess, sodium benzoate intravenously for, [Goldkorn] 1134—ab
anatomy of interlobar fissures, 1933
blood circulation, stasis and pulmonary tuberculosis, [Maestrini] 1955—ab
blood stream resistance in, regulation, 638
cancer, 226
cancer, bronchogenic, [Rosedale] 1847—ab
cancer cells in, fate, [Kost] 1433—ab
cancer, pneumectomy for, 1673
cancer (primary), [Husted] 2268—ab
cancer (primary), diagnosis; treatment, [Bigger] 499—ab
cancer (primary), diagnostic study, [Arkin & Wagner] ★587
cancer (primary), early diagnosis; pneumonectomy for, [Overholt] 1044—ab
cancer (primary), statistics, 1937
cavities, diagnosis, [Wachtel] 258—ab
cirrhosis, second heart sound duplication sign of, [Mura] 165—ab
collapse, atelectasis, [Knipping] 1525—ab
collapse, symposium on, Paris, 1581
complications of amebiasis, [Ochsner] 1522—ab
complications (postoperative), 1403
LUNGS—Continued
complications (postoperative), prophylactic autohemotherapy, [Kárpáti] 1615—ab
condition, differential diagnosis, 402
cystic, [Kjaergaard] 504—ab
cysts and tumors, 395
Disease: See also Pneumoconiosis; Pneumonia
disease (nontuberculous), positive tuberculin test, [Nissler] 417—ab
edema (allergic vernal), peculiar anaphylactic [Engel] 749—ab
edema in renal disorders, [Klima] 1137—ab
edema, motorized oscillating bed for, [Sanders] ★916
Emphysema: See Emphysema
fibrosis (progressive idiopathic), with emphysema, [Hampton] 577—ab
fibrosis, reversible cardiac enlargement, [Rosenblatt] 2177—C
fusospirochetal Infections: See Spirochetosis
gangrene, sodium benzoate intravenously, [Goldkorn] 1134—ab
Hemorrhage: See also Tuberculosis, Pulmonary
hemorrhage (periodic), 1838
iododerma after injecting iodized oil into, [Goldstein] ★1659
macrophage system in pneumonia, [Robertson] 742—ab
puncture in penumonia, [Sappington] 1123—ab
rest by posture, [Pierson] 738—ab
roentgen study in pneumoconiosis, [Sweany] ★1959
roentgen study of encapsulated interlobar effusions, [Rigler] 1522—ab
roentgenograms, triangular images of thoracic bases in children, [Debré] 1134—ab
stenosis (congenital), 942
suppuration, [Trefilov] 664—ab
suppuration (acute), pyopneumothorax complicating, [Wood] 156—ab
surgery, compensatory changes after pneumonectomy, [Rienhoff] 574—ab
surgery, relation of vagus, [O'Shaughnessy] 2262—ab
Tuberculosis: See Tuberculosis, Pulmonary
tumor, superior sulcus (Pancoast), [Frost] 1847—ab
volume during artificial pneumothorax treatment for pneumonia, [Lindskog] 1848—ab
LUPUS erythematosus, gold compounds for, [Wright] 1688—ab
vulgaris: phenylethyl hydnocarpate intradermally, [Burgess] 164—ab
LUSH'US Brand Evaporated Milk, 1987
LUTEOSTERONE, 1808
LYMPH pressure (thoracic duct) in concretio cordis, [Blalock] 958—ab
LYMPHANGITIS, mesenteric, [Kleiber] 1431—ab
LYMPHATIC SYSTEM: See also Lymphangitis
calcified mesenteric nodes, intestinal physiology in, [Golden] 2031—ab
cancer, metastatic inguinal, from penis, [Barringer] ★21
enlargements of nodes, pathology, [Goyle] 578—ab
infectious adenitis or mononucleosis, 1937
tuberculous chancre transmitted by kissing, [Sulzberger] 314—C
tuberculous glands, problem of surgical treatment, 1215
LYMPHEDEMA: See Elephantiasis
LYMPHOBLASTOMAS, [Krumbhaar] ★286
treatment, irradiation, [Desjardins] 2107—ab
LYMPHOCYTES: See also Meningitis, lymphocytic
monocyte ratio in tuberculosis, [Bresci] 2266—ab
types (six), [Isaacs] 326—ab
LYMPHOCYTOMA, atypical primary cutaneous, simulating psoriasis, 2020
LYMPHOGRANULOMA, [Ebbehøj] 1958—ab
Hodgkin's disease, [Krumbhaar] ★289; [Desjardins] 2107—ab
Hodgkin's disease, blood morphology in, [Roth] 326—ab
Hodgkin's disease, Gordon test for, [Rosenberg & Bloch] ★1156
Hodgkin's disease, leukocyte picture in, [Roth] 2193—ab
inguinale, extragenital lesions, Frei test; antimony and potassium tartrate and fuadin for, [David & Loring] ★1875
inguinale, Frei test, antigens from mouse brain, [Strauss & Howard] ★517
inguinale, incidence in St. Louis; Frei test, [Gray & others] ★919
inguinale, infectivity of spinal fluid, [von Haam & d'Aunoy] ★1642
inguinale, lymphopathia venereum, Frei test, [Thompson] ★1869
inguinale, possible transmission to offspring, [Dick] 1613—ab
inguinale, rectal stricture, 1838
inguinale, skin reactions, 46—E
localized in anorectal region (Nicolas-Favre disease), [Aravantinos] 661—ab
LYMPHOID TISSUES, reciprocal relation to myeloid tissue, [Wiseman & others] ★609
LYMPHOMATOID diseases, [Krumbhaar] ★286
LYMPHOPATHIA venereum: See Lymphogranuloma inguinale
LYMPHOSARCOMA, [Krumbhaar] ★288
treatment, 66
LYON, ELIAS P., lectureship honoring, 2075

M

M Factor: See Erythrocytes
McCORMICK Apparatus: See Anesthesia
McGILL University (reorganizes curriculum) 1324; (dean) 1743
MACHINE: See Diathermy; Milking
McINTOSH Junior Metro-Coagulator, 921
McKESSON Oxygen Tent, 1987
Recording Metabolor, 1091
MacNEILLIE, J. C., death, 1406
MACROPHAGE System: See Lungs
MACULA LUTEA, hereditary degeneration, [Lloyd] 1948—ab
idiopathic flat detachment, [Walsh] 1947—ab
MADRID PAEZ, S., death, 1510
MAGGOT therapy in dermatologic practice, [Ayres] 740—ab
MAGNESIUM hydroxide, antiemetic combination, 2256
in Blood: See Blood
metabolism, [Walker] 2105—ab
needs of preschool children, [Daniels] 2196—ab
Oxide: See Rheumatic Fever
Sulfate: See also Chorea, Sydenham's
sulfate, poisoning, [Roller] 1614—ab
Trisilicate: See Peptic Ulcer treatment
MAHONING County Medical Society (Ohio), agreement for care of indigent sick, 1095
MALARIA, Austral Pacific Zone, 139
diagnosis, Henry reaction, [Marchoux] 1047—ab
in nurslings, 1405
Inoculation: See Malaria, therapeutic
International Congress on (third), 2078
mortality rate declines, Georgia, 1667
mosquito day (August 20, 1897) and Sir Ronald Ross, 460—ab
mosquitoes, research on, 1326
Therapeutic: See also Mycosis fungoides; Neurosyphilis; Paralysis, General, of insane
therapeutic, controls optic atrophy, [Clark] 1125—ab
therapeutic, recurrence of inoculation malaria, [Petersen] ★775; [Kopeloff] 1331—C
therapeutic, 10 years' study, Bucharest, 720
treatment, atabrine fails to control epidemic, [Komp] 2192—ab
treatment, atabrine, plasmochin, [Seckinger] 250—ab
MALE hormone: See Testis hormone
MALFORMATIONS: See Abnormalities
MALNUTRITION: See Nutrition
MALPRACTICE: See also under Medicolegal Abstracts at end of letter M
authorization of physical examinations, treatment, operations, autopsies, [Woodward] ★33
damages for injuring sciatic nerve, 1402
suit against doctor for indiscretion, 1833
MALT preparations with cod liver oil and viosterol, Council statement, 1735
MALTED Milk: See Milk
MANGANESE, use in hyperglycemia, 2182
MANIKIN Tea, 1837—BI
MANNITOL hexanitrate, 487
MAPHARSEN: See also Syphilis, treatment
N. N. R., 214
MARBURG Fund: See Foundation
MARCH Foot: See Foot
MARCHIAFAVA, ETTORE, death, 1022
MARCO Brand Evaporated Milk, 707
MARESCH, RUDOLF, death, 1216
MARGARINE: See Oleomargarine
MARGO CCB, 383
MARINE hospital, society favors abolishing, 545
Sponge: See Sponge
MARISCO Menthal Inhaler, 1837—BI
MARKS Test: See Peptic Ulcer
MARRIAGE, federal commission for the protection of German blood, 1214
increase, Germany, 1932
Jewish mixed marriages in Germany, 719
loans, health of applicants for, Germany, 2018
of cousins dangerous? 1506
prenuptial examination, 397
MARSHALL Brand Tomato Juice, 1166
MARTYRS: See also Heroes
bacteriologist dies of meningitis, 129
Dr. Monteiro and Dr. de Andrade die of typhus, 310
Dr. Takahashi victim of Manchurian typhoid, 2174
murder of Dr. Silber C. Peacock on fake call, 220; 1208
murder of Dr. Taubmann by patient's brother, 1404
Roentgen-Ray: See Roentgen Rays
MASCULATION: See Virilism
MASKS: See Gas
MASON, J. TATE, (portrait) 1618; (address) ★1695; (serious illness) 1813—E; (message from) 1817; (interpretation of constitution involving incapacity) 1818; 1903; 1905; (message to) 1908; (installation) 1917; (death) 2252
MASSACHUSETTS Institute of Technology, Cambridge (bacteriology course), 1015
Society for Mental Hygiene, 303
MASSAGE: See Heart; Prostate
MASSEY'S Ephedritone Inhalant: See Ephedritone
MASTITIS: See Breast inflammation
Bovine: See Udders, inflammation

MASTOIDECTOMY, modified (Bondy) radical, skin graft in, [Shambaugh] 1421—ab
MATERNAL health, effect of excessive cigaret smoking on, [Campbell] 1761—ab
health, program, Michigan, 2165
mortality due to septicemia vs. antecedent history of abortion, 1938
mortality (high puerperal), explanation, [Kosmak] ★1436
mortality, lowering by new midwifery service, England, 2169
mortality, present rate discredit to modern obstetrics, 717
mortality rate, public health aspect, [Riley] ★1438
welfare, American Committee on, 1323; 1995
MATERNITY Hospitals: See Hospitals
MATTRESSES, hazard of tetanus in sewing, 2183
MAXILLARY SINUS, radiologic investigation, [Shannon] ★599
MAYFLOWER Brand Oleomargarine, 1987
MEAL, heavy, time of day for, 1224
MEASLES, German: See Rubella
incidence, France, 2249
modified by convalescent blood, confer lasting immunity? [Townsend] 2106—ab
prevention, immune globulin (human), [Lanning] 498—ab; (county wide use) [McGavran] ★1781
prevention, Saint Etienne, France, 1105
MEAT: See also Beef; Rabbit
kosher, ban on schächten, Germany, 1747
lean, minerals in, 1150—ab
MEDALS: See Prizes
MEDIASTINUM: See Pneumomediastinum
MEDICAL CENTER, Jerusalem, plans approved for, 1744
MEDICAL CLINIC: See Clinic
MEDICAL COLLEGE: See Schools, Medical
MEDICAL CONGRESS: See also International; National
of Ceará (first), 1583
MEDICAL CORPS: See Army; Navy
MEDICAL CREDIT Service Bureau: See Economics, Medical
MEDICAL DIATHERMY: See Diathermy
MEDICAL EDUCATION: See Education, Medical
MEDICAL EMERGENCY RELIEF: See Emergency Relief
MEDICAL EXAMINATION: See Physical Examination
MEDICAL EXAMINER system vs. coroner system, [Leary] 1408—C
MEDICAL JURISPRUDENCE: See also Medicolegal Abstracts at the end of letter M
damages for injuring the sciatic nerve, 1402
lawful authorization of physical examinations, treatment, operations and autopsies, [Woodward] ★33
ownership of x-ray films; Supreme Court decision, [Brown] 400—C; 1035—MI
suit against doctor for calling bath servant to remove patient, 1833
Supreme Court holds corporate practice illegal, 632
MEDICAL LIBRARY: See Library
MEDICAL PRACTICE ACTS: See also Medicolegal Abstracts at the end of letter M
aggressive vs. passive attitudes of state board members, [Morgan] 1571—ab
basic science boards, ★1492
enforcement procedure (Texas) [Crowe] 1570—ab; (Ohio) [Platter] 1571—ab
state laws, 1177; 1180
MEDICAL PROFESSION: See Medicine, profession
MEDICAL RESEARCH COUNCIL, annual report, 1580
MEDICAL RESERVES: See Army, U. S.
MEDICAL SCHOOLS: See Schools, Medical
MEDICAL SERVICE: See also under Medicolegal Abstracts at end of letter M
costs and family budget, [Shurly & Bullock] ★298
diagnostic, California Medical Association resolution on, 1168
extension needed, India, 553
for employees on emergency relief payrolls, 1175; 1179
for impoverished cancer patients, Germany, 1404
for indigent, (Emergency Relief Bureau, New York) 304, 1668; (Mahoning County Medical Society agreement) 1095—ME; (A. M. A. Bureau of Medical Economics report) 1181; (Medical Society of Pennsylvania problems) 1211; (Michigan) 1576; (digest of laws, Wisconsin) 1670; [McLester] 1817
for wards of Rural Resettlement Administration, 1176; 1179
free, denied to those able to pay, New York City, 1322
free, for veterans, 1019
group, headed by Dr. C. D. Saul, ruled illegal, 1400
prepaid, subject to insurance laws, Pennsylvania, 390
public, physicians in, Rumania, 1832
rural, questionnaire on, by A. M. A. Bureau of Medical Economics, 1914; 1916; 1919
school, reforms in, England, 636
MEDICAL SOCIETY: See also Societies, Medical
of Milwaukee County film, 1827
of New Jersey, unfair criticism of Council on Pharmacy and Chemistry, 1173; 1188; 1918
of State of New York resolution on medical publicity, 389
of State of Pennsylvania, social problems committee, 1211
MEDICAL STUDENTS: See Students, Medical
MEDICAL WEEK, International, Switzerland, 1748
MEDICAMENTS: See Drugs
MEDICINE: See also Economics, Medical; Education, Medical; Medical Service; Physicians; Surgeons; Surgery; etc.
A. M. A. resolution on division into technical and professional portions, 1822
Academy of: See Academy
aims and methods, Ryle's inaugural lecture at Cambridge, 306
art of, [Metzger] 1207—ab
Aviation: See Aviation
Cults: See Cults
Exhibits: See American Medical Association; San Diego; Texas
Fellowship of, Postgraduate Medical Association, 866
future, China, 1107
German, "new," 478; 1509; 2081
History: See also under Education, Medical; Hospitals, Berlin
history, evolution of diseases, 1812—E
history, medical pageant, 1740
history, revival, Germany, 1106
history, through the ages; exhibit of rare medical books, 554
Industrial: See Industrial
Internal: See Internal Medicine
Legal: See Medical Jurisprudence
organized, A. M. A. resolution on instruction in medical schools, 1188; 1918
organized, Switzerland, 2083
pertaining to sport, 936
practice, attitudes of groups of physicians, [Mason] 1817
practice, changes, Japan Medical Association report, 1217
practice conducted by physicians and not by hospitals, A. M. A. resolution on, 1822; 1906
practice, panel system, Great Britain, [Scammon] 1316—ab
Preventive: See Preventive Medicine
Profession: See also Medicine, organized; Nurses; Physicians; Students, Medical; Surgeons; etc.
profession, and voluntary euthanasia, 549
profession, ascent, reply to H. J. Laski, [Shurly & Bullock] ★297
"profession," definitions, [Woodward] ★1897
profession, discipline and education in England, Horder's address, 1906
profession, integration, 1178; 1180, (Michigan) 1576
progress, in Philippines, 1497—E
Royal Society of: See Royal
social scientists in field of, 124—E; [Bergey] 483—C
socialized, "full steam" or caution in, 1737—E
state, [Mason] 1817
state, debate on, National University Extension Association Debate Committee, 1183; (negative wins, N. C.) 1400
state, Governor Landon opposes, 1810—E
Tax on: See Tax
MEDICINES: See Drugs
MEDICOLEGAL: See Medical Jurisprudence; and under Medicolegal Abstracts at end of letter M
MEGACOLON: See Colon
MEINICKE Reaction: See Tuberculosis, diagnosis
MELANOBLASTOSIS, diffuse, of meninges, [Netherton] 1039—ab
MELANODERMA, postemotional, [Bonorino Udaondo] 580—ab
MELANOMA, black tumors of skin, [Roussy] 501—ab
malignant, [Plewes] 2101—ab
MELANOPHORE Hormone: See Chromatophorotropic Hormone
MELENA with gastroduodenal ulcer, [Meulengracht] 660—ab
MELLOW MILK, Homogenized, advertising leaflet, 1166
MEL-O-TOSE advertising leaflet, 1009
MELVERN Ice Cream, 123
MEMBERSHIP: See American Medical Association; Societies, Medical
MENARCHE: See Menstruation inception
MENDEL, LAFAYETTE B., tribute to, 302; 539; 1187; 1320; (Tokyo) 2174
MENGE Pessary: See Uterus prolapse
MÉNIÈRE'S Disease: See Vertigo, aural
MENINGES, hemorrhage, spontaneous leptomeningeal, [Karbacher] 1429—ab
hemorrhage, subarachnoidal, [Zimin] 344—ab
syphilis, 236
Tuberculosis: See Meningitis, tuberculous
tumor, primary diffuse melanoblastosis, [Netherton] 1039—ab
MENINGITIS, acute lymphocytic, [Toomey] 1423—ab
aseptic, after spinal anesthesia, [Brock & others] ★441
bacteriologist dies of, 129
basilar, headaches due to syphilis or? 486
cerebrospinal, bilirubinemia in, [Katzmann] 256—ab
cerebrospinal fluid cell count in, 1756
cerebrospinal, prophylaxis, France, 2249
diphtheritic (rare), [Carlson & Morgan] ★1164
epidemic, roentgen therapy, [Hippe] 1692—ab
epidemic, treatment, [Wood] 338—ab
epidemics, U. S., (Okla.) 222; 391; (Ky.) 544; 931; 1103; (Mass.) 1209; 1401
etiology, filtrable virus, [Scott] 1603—ab
etiology, influenza bacillus, [Bender] 2115—ab
etiology, Torula histolytica, [Sawers] 255—ab
forms of icterohemorrhagic spirochetosis, 934
in mumps, [Silwer] 1958—ab
incubation period in, 1755
lymphocytic, of virus etiology, [Findlay] 2265—ab
meningococcemia, [Conklin] 577—ab
meningococcic, epidemiology, [Rake] 1764—ab
pneumococcic, [Reimann] 234—C
pneumococcus type XXII, [Hirsch] ★1562
primary, type XXII meningitis, [Hirsch] ★1562
problems created by floods, 1092—E
spirochetal epidemic, in children, 550
streptococcic, recovery, [Marick] ★2238
streptococcic, Vincent serum for, 1673
suppurating, in scarlet fever, [Zischinsky] 584—ab
Syphilitic: See Meninges, syphilis
treatment, measures compared, [Tripoli] ★171
tuberculous (bovine type) in infant vaccinated with BCG, 2170
tuberculous, failure of roentgen treatment, 226
tuberculous, frequency, 2020
typhoid, 1221
MENINGOCELE and urinary incontinence, 67
MENINGOCOCCEMIA, [Conklin] 577—ab
fulminating, Waterhouse-Friderichsen syndrome, [Aegerter] ★1715
MENINGOCOCCUS Meningitis: See Meningitis
MENINGO-ENCEPHALITIS after rubella, [Briggs] 161—ab
MENINGOMYELITIS, 486
MENISCUS, incarcerated, reposition, [Poult] 256—ab
injuries, conservative treatment, [Zimmermann] 503—ab
internal, cystic degeneration, [Satanowsky] 1771—ab
MENNINGER Sanitarium: See Hospitals, psychiatric
MENOPAUSE, artificial roentgen, to prevent postoperative metastases in breast cancer, 1594
hemorrhage (irregular), endocrine therapy, 2179
hemorrhage, radium treatment, [Anselmino] 1693—ab
pituitary gonadotropic function in, [Engelhart] 2116—ab
so-called hot flushes, 18—ab
symptoms, relief, use of estrogenic substance; question of libido, 1029
symptoms, use of estrogenic substance for, especially "splitting" headache, 1592, 2025
MENSTRUATION: See also Menopause
bathing during, 452—ab
cycle and date of birth, [Wahl] 1432—ab
cycle, hemoglobin and erythrocyte in blood, [Leverton & Roberts] ★1459
cycle, variation in interval, [Richards] 155—ab
cyclic changes in vaginal mucosa? [Zondek & Friedmann] ★1051
Disorders: See also Amenorrhea; Dysmenorrhea
disorders, human placental extract (emmenin-Collip) for, [Goldberg] 573—ab
disorders, insulin treatment, [Liegner] 344—ab; [Klaften] 584—ab
disorders, roentgen rays applied to ovary and pituitary for, [Wittenbourg] 1525—ab
edema, controlled by emmenin, [Atkinson & Ivy] ★515
headaches and, 2091
in tuberculous, effect of collapse therapy, [Jameson] 1037—ab
inception and rickets, [Dworzak] 751—ab
inception, constitution and delivery, [Weysser] 1957—ab
inhibited by estrogenic substance, [Zondek] 2206—ab
painful breast and, 101—ab; [Taylor] 1045—ab
preservation after hysterectomy, 1328
safe period, 394
safe period exist? [Araya] 501—ab
safe period for contraception, 1592
safe period trustworthy? [Emge] 960—ab
MENTAL DEFECTIVES: See also Idiocy
first-born, [Luxenburger] 1773—ab
nonhereditary, Germany, 1675
number of sterilized, Human Betterment Foundation report, 1827

MENTAL DEPRESSION, glossodynia, [Gilpin] ★1722
treatment, hematoporphyrin, of depressive psychoses, [Angus] 1599—ab
MENTAL DISEASE: See also Dementia Praecox; Hospitals, psychiatric; Psychosis; etc.
adolescent psychoses and fate of patients with, 295—E
aspects of myxedema, [Akêlaitis] 657—ab
erythrocyte sedimentation rate in, [Gregory] 1854—ab
fingerprint as constitutional mark in, [Møller] 344—ab
in foreign-born, [Malzberg] 571—ab
sinus sepsis and, [Jowett] 1859—ab
symptoms in temporal lobe tumor, [Keschner] 1949—ab
treatment, individualization in prescriptions for nursing care, [Menninger] ★756
MENTAL HYGIENE, development, Netherlands, 2019
educational campaign, 471
International Congress (second), postponed, 475
Massachusetts Society for, activities, 303
preventive aspects of mental health problem, [Casparis] ★2207
social aims, 138
MEN-THO-EZE, 143—BI
MEPHITIBIOSIS: See Carbon Dioxide
MERCURIC Oxide: See Mercury
MERCUROCHROME Treatment: See Burns; Colds
MERCURY, ammoniated, ointment, burns from; prescribed by druggist for skin rash, 1938
bichloride poisoning, roentgen irradiation of kidneys in, [Balázs] 751—ab
diuretic properties of new organic compounds, [Pontius] 416—ab
diuretics by Herrmann et al., [Decherd] 483—C
diuretics in cardiac dyspnea, [Levin] 2263—ab
salicylate, Ampules 1 grain (0.065 Gm.) suspended in Oil 1 cc., 1809
Treatment: See Colds; Syphilis
yellow mercuric oxide 1 per cent; sensitivity to, 404
MERCY Killing (Euthanasia): See Death
MERLO, ERNESTO, honored, 1510
MERTHIOLATE, Saf-T-Top Tincture of Merthiolate 1:1,000, 782
MERZBACHER-PELIZAEUS DISEASE: See Brain
MESENCEPHALON: See Brain tumors
MESENTERY, intestinal obstruction due to hole in; descending colon and sigmoid pass through dense ring in, [Cullen] ★895
METABOLISM: See also Acid, oxalic; Calcium; Carbohydrates; Chlorides; Fat; Magnesium; Sodium chloride; etc.
alcohol effect on, 2171
basal, average, 2163—ab
basal, effect of high carbohydrate diet and insulin on, [Bowen] 1233—ab
basal, low rate and use of desiccated thyroid, [Berkman] ★2042
basal, Read's formula for estimating, 562; 1593
cancer as problem in, [Beard] 332—ab
changes, effect on skin surface temperature, [Bierman] ★1159
citric acid in, 1737—E
disturbance caused by injury, [Cuthbertson] 1608—ab
during pregnancy, 1567—E
during reproductive cycle, [Hunscher] 574—ab
in lipoidosis, [Raeder] 1240—ab
in myasthenia gravis, [Adams] 2192—ab
increased, in hyperthyroidism, [Andrus] 157—ab
increased, of obesity; use and abuse of stimulants, [Short & Johnson] ★1776
McKesson Recording Metabolor (no. 175), 1091
*di*Nitrophenol as Stimulator: See *di*Nitrophenol
obesity, 44—E
studies of pituitary insufficiency, [Bulger] 1851—ab
METAL Foil: See Tin foil
METATARSUS varus or pigeon toes, 67
METEROLOGY, fluctuations in basophilic aggregation counts, [Gowen] 2105—ab
METHANOL: See Methyl Alcohol
METHENAMINE Treatment: See Gallbladder inflammation
METHYL ALCOHOL (methanol, wood alcohol) hazard in gasoline station attendant, 1409
*di*METHYL CARBINOL: See Isopropyl Alcohol
METHYL HEPTINE carbonate: lip stick dermatitis, 470—E; [Landsteiner & Jacobs] ★1112
β METHYL ζ METHYLAMINO-β-γ-HEPTENE: See Heptene
METHYL RED, tests of acidity and alkalinity of urine, 1590
METHYLENE BLUE: See Leprosy, treatment
METHYLTHIONINE CHLORIDE (methylene blue): See Leprosy treatment
METRAZOL, Hypodermic Tablets, 2239
METRITIS: See Uterus
METRO-COAGULATOR, McIntosh Junior, 921
METYCAINE Ophthalmic Ointment 4 per cent, 1565
MEULLER, A. C., eyesight swindler, 711
MEYENBERG All Pure Brand Evaporated Milk, 617
MEZEREUM, value in rubbing liniment, 1514
MICE, field, rat-bite fever from, [Reitzel & others] ★1090
MICHIGAN, pollen content of air in Alpena, (reply) [Durham] 239
State Medical Society (adopts 5 year program) 1209; (integration program) 1576
MICROSCOPE: See also Skin
Bausch and Lomb present their 250,000th to Dr. Novy, 2165
stolen, 715; 864
MICROSCOPY, paraboloid or cardioid condenser for dark field studies, 147
MIDDLE AGE, criminal behavior in, 1567—E
MIDWIVES, use of analgesics, 1104
service (new), England, 2169
MIGRAINE: See also Headache
treatment, chondroitin, 293
treatment, ergotamine tartrate, amniotin and phenobarbital in, [Soltz] 1232—ab
unilateral sweating, 148; (reply) [Stieglitz] 487
MILITARY SURGEONS, Association of, 1498
MILK: See also Casein
acidophilus, Lactobacillus Acidophilus Milk (Towt), 1165
allergy, treatment, [Schloss & Anderson] 1025—C
borne scarlet fever, 1015; 2013
Chocolate: See Beverages
company indicted, Boston, 2075
evaporated, brands accepted by Committee on Foods, 293; 467; 539; 617; 707; 1009; 1166; 1473; 1474; 1735; 1809; 1899; 1987
"fever," 942
frozen, use in infant feeding, 562; [Emerson] 1940
Goat's: See Anemia
grading (official), England, 2247
homogenized ("Mellow Milk"), 1166; (Tru-Li-Pure) 1473
human, Breast Milk Distribution Depot, Berlin, 395
human, effect of freezing, [Emerson] 1940
malted, Borden's, 782
of Magnesia: See Magnesium hydroxide
pasteurized, streptococci from, [Wright] 1428—ab
pasteurized to prevent undulant fever, 1754
Powdered: See Peptic Ulcer treatment
protein, Hoos', 923
Secretion: See Lactation
Sugar: See Lactose
vitamin D, 1664—E; [Jeans] ★2066; ★2150
vitamin D, antirachitic activity, [Haman] 574—ab; (in premature) [Davidson] 879—ab
MILKING machines and mastitis in cows, 1213
MILL: See Paper mill
MILLARD, PERRY H., memorial, 1927
MILLER, ADAM, memorial, 1927
MIND: See Psychic
MINERAL WATER: See also Hydrology
limiting use at health resorts, Academy of Medicine report, 56
MINERALS in lean meat, 1150—ab
MINES, Belgian, gases from fire damp veins in, 1676
MISCARRIAGE: See Abortion
MOCQUOT, Professor, appointment, 1746
MOLD, black, use in producing citric acid, 1019
on bread cause of food poisoning? 2256
MOLES, Hydatidiform: See Uterus
treatment, trichloroacetic acid, [McLaughlin] 1605—ab
MOLLE (A "Brushless" Shaving Cream), 144—BI
MOLONEY Toxoid Test: See Diphtheria
MONALDI Test: See Respiration
MONGOLISM: See Idiocy, mongolian
MONILETHRIX, [Larsen] 1774—ab
MONO-IODO-CINCHOPHEN: See Cinchophen
MONOLA Brand Pineapple, 1565
MONONUCLEOSIS, infectious, 315; [Wiseman & others] ★611
infectious adenitis or, 1937
infectious, bone marrow studies in, [Freeman] 1947—ab
MORANDI, J. E. S. C., sentenced, 387
MORGAGNI'S SYNDROME, [Henschen] 1616—ab
MORPHINE, addict, pain in amputation stump in, 1222
addiction, scopolamine-pilocarpine treatment, [Klingmann & Everts] ★18
MORRHUATE, Sodium: See Hemorrhoids; Hydrocele
MORTALITY: See Appendicitis; Diphtheria; Maternal; Typhoid; Vital Statistics; etc.
Tables: See under Medicolegal Abstracts at end of letter M
MOSENTHAL Concentration Test: See Kidney function tests
MOSQUITOES, antimosquito measures for tropical air line, 1019
day (August 20, 1897) and Sir Ronald Ross, 460—ab
malarial, research on, 1326
MOSTERT, DELLA, operator of "Rest Home," sentenced, 304
MOTHERS: See Maternal; Parents
MOTION PICTURES, available by A. M. A., 1174; 1186
films (educational) to be listed, 931
films for instructing first aid, 228
Medical Society of Milwaukee County film, 1827
MOTOR VEHICLE Accidents: See Automobiles
MOTORIZED Oscillating Bed: See Bed
MOTTLED Enamel: See Teeth
MOUNTAIN: See Altitude, high
MOUSE: See Mice
MOUTH: See also Gums; Jaws; Oropharyngitis; Stomatitis; Teeth; Tongue
burning sensation in, 563; [Rattner] ★2230
ulcer, recurrent, 1936
MOVING PICTURES: See Motion Pictures
MUCHEMORE, G. S., Health Remedy Products, 2088—BI
MUCIN, Gastric: See Stomach
MUCOCELE: See Appendix
MUCOUS MEMBRANE: See also Endometrium; Intestines; Stomach; Vagina
desensitization in fractional roentgen irradiation, [Glauner] 1526—ab
MUD Baths: See Baths
MUMPS: See Parotitis
MURDER: See also Martyrs; Suicide
by plague bacillus, 933
MURMURS: See Heart
MURRAY'S Salve, 143—BI
MUSCLES: See also Myasthenia; Myositis; etc.
Atrophy: See Atrophy
Cramps: See Cramps
degeneration in late adult life, [Nevin] 1770—ab
disorders, aminoacetic acid for, [Terhune] 2263—ab
Dystrophy: See Dystrophy
fatigability, 563
fiber, connection with tendon, 2183
fibers, streptococcus in, in myasthenia gravis, [Butt] 955—ab
injury, sternomastoid, in new-born, [Galloway] ★507
muscular tension when at rest, 1638—ab
skeletal, blood flow through, [Anrep] 422—ab
Sprains: See Sprain
syndrome of diffuse hypertrophy in infants [Debré] 495—ab
tonus, hypotonia after subarachnoid alcohol injection, 1115
transplantation for traumatic deltoid paralysis, [Davidson] ★2237
MUSEUM, medical, (Seattle) 715; (Rochester) 1399; (U. of Michigan) 1825
MUSHROOMS, Cellu Brand, 782
protein is incomplete, [Quackenbush] 574—ab
MUSSEL poisoning and quarantine, California, 2163
MYALGIA: See Myositis, epidemic
MYASTHENIA GRAVIS, metabolism studies in, [Adams] 2192—ab
muscle fatigability, 563
postmortem study, streptococci in and between muscle fibers, [Butt] 955—ab
treatment, physostigmine derivative (prostigmine) in, [Everts] 1232—ab
MYCOSIS: See also Actinomycosis; Blastomycosis; Torulosis
fungoides, fever therapy, malaria; protein, Kettering hypertherm, [Klauder] ★201
treatment, fungus extracts, [Robinson] 158—ab
MYELINS, lipoid, in sputum, [Risi] 169—ab
MYELITIS: See Encephalomyelitis; Spinal Cord
MYELOID Tissues: See Tissues
MYELOMAS, multiple, congo red test, [Rosenblum & Kirshbaum] ★988
multiple, diagnosis by sternal puncture, [Schulten] 2267—ab
MYOCARDIUM: See Heart muscle
MYOMA, cytologic blood changes in, [Vorlicek-Jelinek] 1614—ab
MYOSITIS, chronic, due to staphylococcus, 310
epidemic, acute, [Rector] 73—ab
traumatic ossifying, after elbow dislocation, [Böhler] 2269—ab
MYOTONIA: See also Paramyotonia
electromyographic study, [Lindsley] 1125—ab
MYXEDEMA, [Berkman] ★2042
congenital, diffuse muscular hypertrophy in infants causing athletic appearance, [Debré] 495—ab
heart enlargement in, [Walker] ★1796
pernicious anemia and, [Holbøll] 426—ab
psychiatric aspects, [Akelaitis] 657—ab
treatment, thyrotropic principles, [Schneiderbaur] 168—ab
MYXOGLOBULOSIS: See Appendix

MEDICOLEGAL ABSTRACTS

ADVERTISING: dental; prices for professional service, 410
dental; statutory restrictions valid, 1121
optometry; advertisements containing fixed prices prohibited, 71
osteopathic; deceitful advertising prohibited, 1945
ALIENS: pharmacists; right of state to deny license to alien, 735
ANESTHESIA: death from; malpractice in relation to, 2030
skill and care required of anesthetists, 2030
APPENDICITIS: workmen's compensation in relation to, 1760
ASSAULT AND BATTERY: operation, unauthorized, as constituting, 154

Medicolegal Abstracts—Continued
BASIC SCIENCE ACTS: chiropractors must comply with requirements of, 323
constitutionality of Washington act, 323
BOILS: See Insurance, Accident
BOTULISM: workmen's compensation in relation to, 2190
BUERGER'S DISEASE: workmen's compensation in relation to, 153
BURNS: See Hospitals, charitable; Malpractice
CANCER: See Malpractice
CATARACTS: See Malpractice
CHILDBIRTH: See also Malpractice
"born;" when life begins, 1597
ergot; overdose due to pharmacist's error, 153
CHIROPRACTIC: basic science requirement valid, 323
cancer; treatment by "Koch" method, 2189
"chiropractic as taught in chiropractic schools;" construction of phrase, 2189
drugs; treatment of cancer by "Koch" method, 2189
fracture of patient's rib by practitioner, 2190
hypodermic syringes; right to use, 2189
"measures incident to care of the body;" construction of phrase, 2189
COLLEGES: See Schools
COMPENSATION OF PHYSICIANS: contract; oral; when enforceable, 1519
fraudulent misrepresentations by physician; recovery by patient of fee paid, 244
liability of: employer, for services to farm tenants, 2030
liability of: employer, on oral contract, 1519
liability of: municipality, for treatment rendered indigent, 72
licenses; void license as precluding recovery of fee, 244
roentgenograms; refusal to deliver to patient no justification for nonpayment of fee, 1035
witnesses, expert; attorney's right to obligate client to pay, 735
CONTRACTS: See Compensation of Physicians
CORPORATIONS: dentistry; right to practice, 1121
injunction to restrain unlawful practice of optometry, 1519
optometry; right to practice, 1519, 2100
optometry; subterfuge to evade optometry practice act, 2100
DAMAGES: See also Malpractice
prenatal injuries; liability for death of baby, 1597
DEATH: prenatal injuries; liability for resulting death of baby, 1597
DENTAL PRACTICE ACTS: advertising; "fixed prices," 410
advertising; statutory restrictions valid, 1121
colleges; practice of dentistry by, 244
corporations; practice of dentistry by, 1121
dentures; preparation of as practice of dentistry, 244
dentures; repair of as practice of dentistry, 244
exemptions; negativing of, 244
licenses, revocation; "advertising prices for professional service," 410
teeth; cleaning of as practice of dentistry, 244
DENTISTS: See Dental Practice Acts; Malpractice
DIABETES MELLITUS: strain (over-exertion) as cause of, 244
workmen's compensation in relation to, 244
DISEASES: See also particular diseases; Workmen's Compensation Acts
lay testimony concerning, 72
DRUGS: contaminated mineral oil; liability of pharmacist for sale of, 1686
DYES: fur; liability for injury from, 1121
hair; liability for injury from, 1121
idiosyncrasy no defense to action for injury from, 1121
EMBALMERS: licenses; revocation; causes for must be specific, 1417
licenses; revocation; inherent power of board to revoke, 1417
ENCEPHALITIS: epidemic; health insurance in relation to, 1846
epidemic; physician totally disabled by, 1846
EPILEPSY: accident insurance in relation to, 1946
trauma as cause of, 1946
ERGOT: See Childbirth
EUGENICS: sterilization, compulsory; Alabama bill unconstitutional, 154
sterilization, compulsory; "cruel and unjust punishment," 154
sterilization, compulsory; due process of law, 154
EVIDENCE: See also Malpractice; Workmen's Compensation Acts
hospital records; admissibility, 2190
mortality tables; admissibility, 651
witnesses, expert; fees; attorney's right to obligate client to pay, 735
witnesses, lay; testimony concerning disease, 72
EXPERT WITNESSES: See Evidence, witnesses, expert; Malpractice, evidence, witnesses, expert
EYE: See Malpractice
FRACTURES: See Malpractice
GONORRHEA: urethritis attributed to drugless healer's treatment, 323
HEART DISEASES: insurance, health, in relation to, 2190
HERNIA: mesenteric; fall as cause of, 493
strain as cause of, 1945
workmen's compensation in relation to, 493
HOSPITALS, CHARITABLE: See also Hospitals, Governmental; Hospitals, in General
liability for: burns, hot water bottle, 71
liability for: sponge, left in patient, 494
liability to pay patient, 1228
status; criteria of charitable character, 71
HOSPITALS, GOVERNMENTAL: county's liability to pay patient, 1228
status, criteria of, 1228
HOSPITALS, IN GENERAL: records; admissibility in evidence, 2190
visitors; liability for injury to, 1417
HYPERSENSITIVENESS: see Dyes, idiosyncrasy
HYPODERMIC SYRINGES: chiropractor's right to possess and use, 2189
IDIOSYNCRASY: See Dyes
INDIGENTS: medical care; duty of municipality, 72
INJURIES: prenatal; liability for death of baby, 1597
INSURANCE, ACCIDENT: See also Insurance, health; Insurance, indemnity
boil, intranasal; septicemia following picking, 1846
degeneration of liver in relation to accident, 736
disease, death from; construction of exclusion from policy, 736
disease, pre-existing, in relation to, 736
septicemia following picking of boil, 1846
septicemia following trauma, 950
"surgical treatment"; extraction of teeth as constituting, 1597
teeth; death from extraction as accidental death, 1597
INSURANCE, HEALTH: encephalitis, epidemic; physician totally disabled by, 1846
epilepsy due to trauma antedating policy, 1946
heart disease; "total permanent disability" in relation to, 2190
INSURANCE, INDEMNITY: notice of claim; failure of physician to give, 1760
LIVER: degeneration of; trauma as cause of, 736
MALPRACTICE: abandonment of patient, 651
agency; liability of physician-principal for negligence of physician-employee, 493
anesthesia; death attributed to negligent preoperative examination, 2030
anesthesia; duty of physician to ascertain patient's condition, 2030
anesthetists; degree of skill and care required, 2030
assistants; liability for negligence of, 411, 493
bandages; tardiness in removing, 652
burns; hot water from upset sterilizer, 411
cancer; mistake in diagnosis, 651
cataracts; impaired vision attributed to operation, 153
childbirth; cesarean section; sponge left in patient, 494
chiropractors; fracture of patient's rib, 2190
covenant not to sue; concealment of cause of action in relation to, 652
damages; apportionment of between original injury and subsequent malpractice, 1520
dentists; extraction of abscessed tooth; death following, 1846
diagnosis; duty of physician, 2030
diagnosis; mistake in, 651, 1685, 1946
drainage tubes; accidentally left in patient, 410
drugless healer; urethritis following treatment for gonorrhea, 323
employee of physician; liability for negligence of, 493
evidence; quantum of testimony as determining factor, 877
evidence; res ipsa loquitur, 411, 494
evidence; roentgenograms, enlargements of, 877
evidence; testimony of non-sectarian practitioner admissible against drugless healer, 323
evidence; witnesses, expert; court may not ignore testimony of, 568
evidence; witnesses, expert; necessity for, 494, 949, 2190
evidence; witnesses, expert; opinion invading province of jury, 877
experimentation on patients, 651
eye; failure to remove steel particle from eye, 410
foreign bodies; drainage tube accidentally left in patient, 410
foreign bodies; glass in wound, failure to remove, 949
foreign bodies; res ipsa loquitur, 411, 494
foreign bodies; sponges accidentally left in patient, 411, 494
foreign bodies; sponges; custom for nurse to count sponges no defense, 494
foreign bodies; statute of limitations, 410
foreign bodies; steel particle, failure to remove from eye, 410
foreign bodies; suit instituted thirteen years after operation, 1760
fractures; failure to make second roentgenogram, 1685
fractures; impacted fracture of hip; treatment resulting in fibrous union, 1685
fractures; ischemic paralysis following fracture of humerus, 877
fractures; mistake in diagnosis; liability for, 1685
gonorrhea; urethritis following treatment by drugless healer, 323
indemnity insurance; notice of claim; failure of physician to give, 1760
independent contractor; physician-employee as, 493
injuries, pre-existing, aggravated by treatment; release of tort feasor releases physician, 568
joint liability of physicians, 735
judgment of physician; selection of method of treatment, 1846, 1946
knee injury; failure to repair severed tendon, 493
limitation of actions; concealment of cause, 652
limitation of actions; foreign bodies, 410
locum tenens; liability for negligence of, 493
method of treatment; no negligence in choice of, 1846, 1946
negligence; physician's negligence need not be sole cause of injury, 153
operations; consent; liability for operating without securing, 154
palate; removal of during tonsillectomy, 72
paralysis, ischemic; following fracture of humerus, 877
patient as business invitee, 411
pillars of the fauces; removal of during tonsillectomy, 72
roentgenograms; admissibility of enlargements in evidence, 877
roentgenograms; delay in making in leg injury case, 1946
roentgenograms; failure to make second roentgenogram in hip fracture, 1685
septicemia following treatment of wound, 949
skill and care; standards; by which nonsectarian healer judged, 949, 2030
skill and care; standards; by which sectarian healer judged, 323
sponges; accidentally left in patient, 411, 494
sponges; custom for nurse to count no defense, 494
sponges; res ipsa loquitur, 411, 494
streptococcus infection; ankylosis of wrist following treatment, 1520
syphilis; failure to diagnose, 651
tonsillectomy; blindness attributed to, 154
tonsillectomy; palate, uvula and pillars removed, 72
tooth; death following extraction of abscessed tooth, 1846
tort feasors; release of as affecting physician's liability for malpractice, 568
urethritis attributed to treatment for gonorrhea by drugless healer, 323
uvula; removal of during tonsillectomy, 72
verdicts; joint and several liability of physicians, 735
wrist; ankylosis of following treatment of infection, 1520
MEDICAL PRACTICE ACTS: See also Dental Practice Acts; Embalmers; Optometry Practice Acts; Osteopathic Practice Acts; Pharmacy Practice Acts
aliens; denial of license to, 735
chiropractic; treatment of cancer by "Koch" method, 2189
corporations; practice of medicine by, 1121
corporations; practice of optometry by, 1519, 2100
enforcement; injunction to restrain unlawful practice, 1519
examining boards; determination of reputability of medical school, 1336
examining boards; hearings; proceedings need not be recorded stenographically, 1336
examining boards; hearings; reputability of medical schools; applicants right to demand and to attend, 1336
exemptions; faith healing, 1945
faith healing; exempted from act, 1945
licenses; reciprocity; reputability of school of graduation, 1336
licenses; revocation; "immoral dishonorable or unprofessional conduct," 71
medical schools; determination of reputability of; applicant's right to demand and to attend hearing, 1336
MEDICAL SERVICES: contract to pay for; fraud as vitiating, 244
indigents; duty of municipality, 72
MORTALITY TABLES: admissibility in evidence, 651
NEUROSES: workmen's compensation in relation to, 1418
OPTOMETRY PRACTICE ACTS: advertising of fixed prices prohibited, 71
corporations; practice of optometry by, 1519, 2100
corporations; subterfuge to evade act, 2100
enforcement; injunction to restrain unlawful practice, 1519
examining boards; hearings, sufficiency of notice, 2260

Medicolegal Abstracts—Continued
OPTOMETRY PRACTICE ACTS—Continued
licenses; revocation; hearings, sufficiency of notice, 2260
licenses, revocation; "immoral, dishonorable or professional conduct," 71
optical departments; optometrist need not be in charge of, 71
OSTEOPATHIC PRACTICE ACTS: advertising osteopathic business; deceitful advertising, 1945
licenses; revocation; deceitful advertising, 1945
PARALYSIS, ISCHEMIC: See Malpractice
PHARMACISTS: See also Pharmacy Practice Acts
drugs; liability for sale of contaminated mineral oil, 1686
poisons; sale to minor; liability, 1227
poisons; statutory restriction on sale; violation as negligence per se, 1227
prescriptions; error in compounding, 153
professional status of pharmacists, 735
PHARMACY PRACTICE ACTS: aliens; denial of pharmacist license to, 735
PNEUMONIA: infection of face as cause of, 1519
workmen's compensation in relation to, 1519, 1685
POISONS: See also Pharmacists
dyes; liability for injury from, 1121
PRESCRIPTIONS: pharmacists; error in compounding, 153
ROENTGENOGRAMS: See also Evidence; Malpractice
ownership in physician, 1035
SCARLET FEVER: workmen's compensation in relation to, 1035
SCHOOLS: dental; practice of dentistry by, 244
medical; reputability, determination by medical examining board, 1336
SEPTICEMIA: accident insurance in relation to, 950, 1846
malpractice in relation to, 949
streptococcic infection attributed to debility following trauma, 878
SILICOSIS: disability as caused by; expert testimony, 2100
not an occupational disease, 2260
workmen's compensation in relation to, 1122, 2100; 2260
SPONGES: See Malpractice
STERILIZATION, EUGENIC: See Eugenics
STRAIN (OVER-EXERTION): diabetes mellitus attributed to, 244
hernia attributed to, 1945
ulcer, duodenal; perforation attributed to, 411
ulcer, gastric; perforation attributed to, 411
ulcer, peptic; perforation attributed to, 411
SUNSTROKE: workmen's compensation in relation to, 1519
SYPHILIS: diagnosis; malpractice in relation to, 651
TEETH: See also Malpractice, dentists
extraction as constituting "surgical treattreatment,"1597
TRAUMA: appendicitis aggravated by, 1760
Buerger's disease aggravated by, 153
epilepsy attributed to, 1946
liver, degeneration of, as caused by, 736
premature childbirth caused by; liability for death of baby, 1597
streptococcic infection attributed to debility following trauma, 878
ULCERS: duodenal; perforation attributed to strain (over-exertion), 411
gastric; perforation attributed to strain (over-exertion), 411
peptic; perforation attributed to strain (over-exertion), 411
URETHRITIS: acute; treatment for gonorrhea by drugless healer as cause of, 323
VENEREAL DISEASES: gonorrhea; urethritis attributed to drugless healer's treatment, 323
syphilis; failure of physician to diagnosis, 651
WORDS AND PHRASES: "accidental means," 950
"advertising prices for professional service," 410
"any and every kind of duty pertaining to his occupation," 1846
"born alive," 1597
"chiropractic as taught in chiropractic schools," 2189
"hernia," 493, 1945
"immoral, dishonorable or unprofessional conduct," 71
"measures incident to the care of the body," 2189
"occupational disease," 2260
"pathology," 323
"poor person in need of assistance," 72
"profession," 735
"surgical treatment," 1597
"symptomatology," 323
"total permanent disability," 2190
"totally disabled," 1846
WORKMEN'S COMPENSATION ACTS: appendicitis, 1760
botulism, 2190
Buerger's disease, 153
diabetes mellitus, 244
diseases: see also particular diseases hereunder
WORKMEN'S COMPENSATION ACTS—Continued
diseases; contagious, 1035
diseases; in general, 2190
diseases; occupational (silicosis), 2260
diseases; pre-existing; appendicitis, 1760
evidence; conflict of medical testimony; award based on minority view, 2100
hernia; epigastric, 1945
hernia; mesenteric, 493
medical fees; board's jurisdiction in absence of claim by employee, 1036
medical fees; physician's right under act to initiate proceedings to collect, 1036
neuroses, 1418
pneumonia, 1519, 1685
scarlet fever, 1035
silicosis; disability as caused by, 2100
silicosis; not an occupational disease, 2260
silicosis; statute of limitations, 1122
sunstroke, 1519
ulcers; duodenal; perforation of, 411
ulcers; gastric; perforation of, 411
ulcers; peptic; perforation of, 411

N

N Factor: See Erythrocytes
N. N. R.: See American Medical Association
NAILS, biting in children, 944
brittle finger nails, 1515
cystine content, technic for determining, 943
striae in arsenical polyneuritis, [Mees] 968—ab
NAPHTHA jag, in gasoline station attendant, 1409
NARCOLEPSY: See Sleep disorders
NARCOSUSTAINED Therapy: See Psychosis
NARCOTICS: See also Harrison Narcotic Law; Morphine; Opium
Addiction: See Morphine
bureau to combat violation of antinarcotic laws, Germany, 638
control by Chinese government, 1108
drugs, professional use, state legislation, 1177; 1180
federal service, reorganization, 1176; 1180
legislation in relation to licensure, [Woodward] 1569—ab; [McIntyre] 1572—ab
traffic, (U. S.) 1744; (League of Nations report), 1930
NASOPALATINE DUCT cysts, [Goodman] 1605—ab
NATIONAL: See also International; and under list of Societies at end of letter S
Academy of Sciences, Public Welfare Medal, 2075
Antituberculosis Congress, Italy, 1021; 1933
Board of Medical Examiners, [Rodman] 1395—ab; [Baker] 1396—ab; ★1493
Committee on Mental Hygiene, (research on dementia praecox) 132; (conference on psychiatric education) 474; 2014
Congress of Internal Medicine, Italy, 639
Congress of Obstetrics and Gynecology, A. M. A. resolution on, 1996; 1997
Congress of Orthopedics, Italy, 721
Congress of Parents and Teachers, (traffic safety program) 1743; (extends greetings to A. M. A.), 1819
Congress of Urology, fourteenth, 310
Formulary, epitome, report, 1171
Health Service, China, 229
Medical College of Shanghai, new, 1107
Research Council, (grants) 50; 1743
Safety Council (5 year program to reduce auto accidents) 132; 1018
Socialist Nurses' Association, Germany, 58
Society for Advancement of Gastro-Enterology, (first convention) 1928
Society for Prevention of Blindness, 2078
Surgical Congress, Italy, 395
Syndicate of Physicians plan of fees, Italy, 2251
Tuberculosis Association, (meeting) 715; (health education seminar) 1018
Tuberculosis Council, Cuba, 2078
University Extension Association Debate Committee, 1183
NATURE cure physicians, convention, 1327; 2081
NAUSEA: See also Sea Sickness; Vomiting
epidemic in Roskilde, [Henningsen] 1342—ab
NAVY, U. S., (examination for medical corps) 223; (annual report) 1104
NECK, arthritis, [Hanflig] ★523
cutaneous tags, [Templeton] 1689—ab
eczema (chronic) on back of, treatment, 1591
injuries, brace for handling patients, [Wright] ★1467
limber neck in chickens, 1027; (reply) [Murray] 1682
Ringworm: See Ringworm
NECROPSIES: See Autopsies
NECROSIS: See Heart; Kidney; Lipoid; Pancreas
NEEDLE in right side of heart, [Nissen] 167—ab
prick, danger in operation on syphilitic, 486
suturing (new), [Nelson] ★1005
NEGROES, mongolism in, [Gesell] ★1146
pigmentation, sunlight and nutrition, 218—E
resemblance to gipsies, 148
syphilis and primary glaucoma, [Beckh] 570—ab
NEGROES—Continued
syphilis in pregnancy; questionnaire, [Exner] ★488
NEOARSPHENAMINE, bone marrow depression and encephalitis after, [Cowper] 1426—ab
injection, mortality statistics, 1114
intravenously or intramuscularly, difference in effects, 646
NEODIARSENOL, 1.8 Gm. Ampoules, 617
NEO-SYNEPHRIN, continuous use of, in nose, 148
NEPHRITIS: See also Pyelonephritis
acute, after injecting staphylococcus anatoxin, 1403
complicating transfusion, [Tzanck] 81—ab
glomerulonephritis, plasma cholesterol concentration in, [Cantarow] 155—ab
glomerulonephritis produced by specific serums, [Arnott] 2200—ab
hematuric, of children, [Nobécourt] 256—ab
toxic, poisoning by Chichester's Pills, [Motley & McGehee] ★1163
NEPHROLITHIASIS: See Kidney calculi
NEPHROSIS: See Kidney disease
NERVES: See also Anesthesia; Nervous System; Paralysis
auditory, division for Ménière's disease, [McKenzie] 2104—ab
auditory, involved after tetanus antitoxin, [Cutter] ★1006
Axillary (circumflex): See Paralysis
components of teratomas, [Willis] 2111—ab
Denervation: See Adrenals
excitability caused by cobra venom, [Cicardo] 166—ab
injury, return of function after, 2025
lipid constituents in diabetes, [Jordan] 1231—ab
optic atrophy (syphilitic), 1840
optic atrophy (syphilitic), malaria to control, [Clark] 1125—ab
peripheral, in subacute combined degeneration of cord, [Greenfield] 1131—ab
Phrenic Paralysis (induced): See Tuberculosis, Pulmonary
Phrenicectomy: See also Tuberculosis, Pulmonary
phrenicectomy, atrophy of diaphragm after, [Galan] 1525—ab
phrenicectomy or phrenic alcoholizations, [Jullien] 1341—ab
phrenicectomy, syndromes after, [Valdés Lambea] 661—ab
presacral, resection in dysmenorrhea, etc., [Bailey] 339—ab
Sciatic: See also Sciatica
sciatic, damages for injuries, 1402
sensations in legs in anemia, 944
seventh, poliomyelitis virus transmitted by, [Toomey] 879—ab
splanchnic resection and vagotomy, effect on gastric motility, [Barron] 413—ab
splanchnic, section in juvenile diabetes, [de-Takáts] 871—C
symptoms in simple achylous anemia, [Abramson] 968—ab
Trigeminal: See Neuralgia
vagal inhibition, 1080—ab
vagus, pressing hard on, to relieve paroxysmal tachycardia, 1333
vagus, relation to lung surgery, [O'Shaughnessy] 2262—ab
NERVOUS SYSTEM: See also Brain; Spinal Cord
Autonomic: See Nervous System, Sympathetic
central, tuberculomas, [Jaffé] 1600—ab
changes in diabetes, [Sheppe] 659—ab
complications after spinal anesthesia, [Brock & others] ★441; [McDonald & others] 1220—C; [Schwartz] 1513—C
complications from freeing pleural adhesions, [Mistal] 1429—ab
disorders, diagnosis, 2090
involvement in trichiniasis, [Merritt & Rosenbaum ★1646
involvement in trichloroethylene intoxication, [Eichert] ★1652
sequels in carbon monoxide poisoning, [Shillito & others] ★669
Syphilis: See Neurosyphilis
NERVOUS SYSTEM, SYMPATHETIC, [Kuntz] ★345
autonomic, essential anatomy, [Kuntz] ★345
autonomic, essential pharmacology, adrenergic and cholinergic fibers, etc. [Jackson] ★357
autonomic, function tests, [Brown] ★353
autonomic; importance of paraganglionic tissue, 869
autonomic, role in pain production, [Davis & Pollock] ★350
autonomic, symposium on, [Kuntz] ★345; [Davis & Pollock] ★350; [Brown] ★353; [Jackson] ★357; [Adson] ★360; (discussion) 366
disorders, after encephalography, [Boeters] 663—ab
indications for operations on, [Adson] ★360
lumbar, procaine infiltration for phlebitis, 56
Sherrington phenomenon, [Bülbring] 1609—ab
Surgery: See also Sympathectomy
surgery of lumbar, 1405
NESSLERIZATION: See Blood urea nitrogen
NETTER, ARNOLD, death, 1325
NEUFELD Reaction: See Pneumococcus

NEURALGIA, occipital, alcoholization of carotid for, [Kessel] 748—ab
treatment, trichloroethylene intoxication, [Eichert] ★1652
trigeminal (bilateral) [Harris] 1124—ab
trigeminal (nasal branch) [Charlin] 257—ab
trigeminal, tic douloureux, 645
NEURINOMA, intrathoracic, [Dyggve] 1774—ab
NEURITIS, cauda equina, after spinal anesthesia, [Brock & others] ★441
crural, vitamin B_1 in [Hesse] 1614—ab
in adult, [Haden] ★261
polyneuritis after mumps (rare) 867
polyneuritis and cotton dyes, 237
polyneuritis (arsenical), striae of nail in, [Mees] 968—ab
polyneuritis, diabetic, 2020; 2180
Sciatic: See Sciatica
NEUROFIBROMATOSIS in pregnancy, [Sharpe & Young] ★682
multiple tumor syndrome in male, [Davis & others] ★1359
NEUROLOGISTS, meeting, Germany, 57
NEUROLOGY, Congress of, France, 935
department created at U. of Illinois, 1320
hereditary biology, problems, 57
NEUROMA, painful, sympathectomy in, [Adson] ★364
NEUROSIS: See also Angioneurosis; Psychoneurosis; under Medicolegal Abstracts at end of letter M
Aeroneurosis: See under Aviation
correlation of psychic and somatic disorders, [Fetterman] ★26
crampus and gout, [Vogl] 1137—ab
NEUROSYPHILIS: See also Meninges syphilis; Nerves, optic; Paralysis, General, of insane; Tabes Dorsalis
asymptomatic, 1031
cerebrospinal fluid in, 2090
cerebrospinal syphilis, 1029
incidence, effect of inadequate treatment of early syphilis, [Kemp] 880—ab
incidence, Massachusetts, [Nelson] ★108
malaria to control optic atrophy due to, [Clark] 1125—ab
parenchymatous meningovascular, 236
treatment, fever, 1333
treatment, malarial, [Menzies] 77—ab; (10 years' study, Bucharest) 720
treatment, use of rat-bite fever, [Rothström] 1434—ab
NEUTRAL RED, intravenous gastric chromoscopy [Allodi] 1692—ab
NEVUS, pigmented extensive, with melanoblastosis of meninges, [Netherton] 1039—ab
Vasculosus: See Angioma
NEW AND NONOFFICIAL REMEDIES: See American Medical Association
NEW ENGLAND Obstetrical and Gynecological Society, 1928
Society of Psychiatry awards, 544
NEW JERSEY Medical Society unfair criticism of A. M. A. Council, 1173; 1188; 1918
NEW LIBERTY Brand Pineapple, 1565
NEW YORK Academy of Medicine, memorandum on oxygen administration, 2188
Committee on the Study of Hospital Internships and Residencies, [Curran] ★753
Diabetes Association, report, 1826
NEWSPAPER: See also Press
bars physicians and dentists from advertising, New York, 2013
NICKEL plating, industrial hazard in, 1681
NICOLAS-FAVRE Disease: See Lymphogranuloma
NICOLLE, CHARLES JEAN HENRI, death, 864
NICOTINE: See also under Tobacco
poisoning (acute) from Nikoteen insecticide, [Franke & Thomas] ★507
NIGHT, loss of weight during, 239
NIKOTEEN: See Nicotine
NITROGEN in Blood: See Blood
metabolism, relation to adrenal cortical hormone and thyroxine and, 542—E
nonprotein, postoperative retention, 1931
tissue saturation with, relation to caisson disease, [Shilling] 163—ab
*di*NITROPHENOL, accidents after medicinal use, 1745
account for continued high metabolic rate several months after use? 730
Council report, 1172
effect on blood velocity, [Wohl] 575—ab
effects on metabolism, [Tainter] 161—ab
nostrum, Dilex-Redusols, 1587—BI
nostrum, Slim, toxic effects, [Hitch & Schwartz] ★2130
poisoning, with thrombocytopenia, etc., [Imerman & Imerman] ★1085
relation to leukopenia, [Kracke] 1422—ab
toxicity, 1513
use and abuse of metabolic stimulants, [Short & Johnson] ★1776
NOBÉCOURT, Professor, 1508
NODULES: See Skin
subcutaneous, in arthritis, [Katz] 1432—ab
NOISE, campaign against, (New York) 2013; (England) 2016; (California) 2073; (Philadelphia) 2077
cracking, in jaws, (reply) [Narat] 318
NOMENCLATURE: See Terminology
NORGAARD'S Reaction: See Feces
NORMA Effervescent Preparation, 143—BI
NORTHWESTERN University, chondroitin committee policy, 293
NOSE: See also Colds; Nasopalatine Duct; Rhinitis
Accessory Sinuses: See Sinuses, Nasal
Allergy: See Hay Fever
continuous use of astringent solutions in, 148
epithelioma of skin of bridge, roentgenotherapy cures, [Friedman & Engel] ★1879
Hospitals: See Hospitals
intranasal protection aginst poliomyelitis, etc., [Peskind] 483—C; [Armstrong] 1424; [Hudson & others] ★2037
pathology of rhinosporidiosis, [Karunaratne] 1428—ab
septum, perforation, 646
Streptococcus hemolyticus from, [Hare] 339—ab
surgery, control of bleeding, [Brown] 2265—ab
NOSTRUMS: See also Quackery
advertising, bill restricting, England, 1402; 1829
advertising, radio station WEMP to refuse, 1401
ethical "patent medicines," Vegemucene, 1172
NOTCH, Sternal: See Jugular Notch
NUCLEOPROTEIN accumulations, thymus as essentially a focus of, 869
NUCLEUS: See Cells; Tumors
NUMBNESS of thumb with paroxysms of pain, 316
NUPERCAINE ointment, use in eye to relieve pain, [Minnich] 738—ab
NURSES, medical students serve as, U. of Freiburg, 309
National-Socialist Association, Germany, 58
school, Japan, 2173
tuberculosis in, 637
NURSING care for psychiatric patient, individualization in prescriptions, [Menninger] ★756
schools of, in hospitals, ★795
NUTRITION: See also Diet; Food; Infants, feeding; Vitamin
deficiency disease (multiple specific) in adult, [Haden] ★261
effect of depression on, of adults, children, workmen, [McLester] ★1865
government control of lectures on, Germany, 395
iron in, [Widdowson] 2110—ab
League of Nations commission on, 306
malnutrition, Minneapolis children free from, 929
malnutrition, serum lipoids in, [Man] 1603—ab
national health and, England, 1829
pigmentation and sunlight, 218—E
significance of zinc, 1011—E
study in adult life, 1826

O

OBESITY: See also Morgagni's Syndrome
hereditary factor, [Gurney] 1763—ab; 1989—E
hypophyseothyrogenic, and emaciation, [Wahlberg] ★1968
metabolism (increased) of, [Short & Johnson] ★1776
nostrum (dinitrophenol), Dilex-Redusols, 1587—BI
nostrum (dinitrophenol), Slim, toxic results, [Hitch & Schwartz] ★2130
of hypothyroid or hypopituitary type, differentiating, 1681
postencephalitic, 869
skin temperature after ingesting food in, [Booth] 1763—ab
treatment, diet, [Hanssen] 1694—ab
treatment, dinitrophenol poisoning, [Imerman & Imerman] ★1085; [Hitch & Schwartz] ★2130
treatment, dinitrophenol; thyroid, [Short & Johnson] ★1776
treatment, thyrotoxicosis during; overdosage of thyroid extract, 2023
OBITUARIES: See List of Deaths at end of letter D
OBSTETRICIAN, prevention of birth injury and, [Galloway] ★505
OBSTETRICS: See also Abortion; Labor; Midwives
American Board of, examinations, 2078
Anesthesia in: See Anesthesia
courses in, federal funds for, Wisconsin, 1827; 2077
modern, present maternal mortality rate discredit to, 717
National Congress of, A. M. A. resolution on, 1996; 1997
New England Society, meeting, 1928
outpatient, in poor, insanitary homes, [Buxbaum] 1761—ab
teaching, public health aspect, Maryland, [Riley] ★1438
training medical students in, [Kosmak] ★1435; (correction) 2089—C; [Adair] ★1441; [Reed] 1204—ab; (discussion) 1205—ab
OCCIPITAL Lobectomy: See Brain
OCCUPATIONAL DISEASES: See Industrial
OCCUPATIONAL THERAPY, curative workshop, Baltimore, 632
OCEAN CLEAR Lobsters, advertising booklet, 1009
ODOR, of heated house dust, effect on appetite, [Winslow] 952—ab
OHIO Maid Brand Oleomargarine, 1987
State University, Howald Scholarship, 473
OIL: See also Castor Oil; Cod Liver Oil; Fat; Lipids
Chaulmoogra: See Arthritis treatment
Iodized: See Iodized Oil
Liver Oil: See Liver
of Camphor: See Camphor
of Peppermint: See Peppermint
Soluble Anesthetics: See Anesthesia
Treatment: See Ragweed dermatitis
vegetable, place in diet, [McClendon] 64—C; (reply) [Taub & Zakon] 642—C
Wheat Germ: See Vitamin D
yellow T, dermatitis from wrist watch straps, 1738—E
OINTMENT: See Mercury; Metycaine; Nupercaine; Scarlet Fever immunization
Wilkinson's: See Ulcer, crural
OKAJIMA, KEIJI, death, 2174
OLD AGE, assistance plan, Texas, 1827
care for aged physicians, Austria, 479
celebrate woman's 108th birthday, 54
major surgery in, [Newton] 1954—ab
obliterating vascular disease in, 646
Swiss Physicians' Old Age and Life Insurance Society, 2084
OLEIC ACID: See Acid
OLEOMARGARINE, brands accepted, 1009; 1661; 1809; 1899; 1987
OLIARO, GUGLIELMO, death, 2020
OLIGURIA: See Urine
OMNADEN: See Leukopenia, treatment
OOPHORITIS: See Ovary inflammation
OPERATING ROOMS: See Anesthesia; Surgery
OPERATIONS: See Surgery
OPHTHALMIA, gonorrheal, fever therapy (Kettering hypertherm), [Metz] ★1658
OPHTHALMIC Lenses: See Glasses
Ointment: See Metycaine
OPHTHALMOLOGISTS, A. M. A. resolution on teaching and consulting with optometrists, 1922; 1997
optometrists and, 926—E
OPHTHALMOLOGY, Association for Research in, 1505
medal awarded by U. of Buffalo, 633
Oregon Academy of, graduate course, 714
OPHTHALMOSCOPE, portable dark room (umbrella with curtains) [Olsho] ★115
value in hypertensive toxemia of pregnancy, [Hallum] ★1649
OPIUM, contraindication in asthma, 67
OPSONOCYTOPHAGIC Index: See Blood Transfusion
OPTIC Atrophy: See Nerves
OPTOMETRISTS: See also under Medicolegal Abstracts at end of letter M
A. M. A. resolution on teaching and consulting with, 1922; 197
ophthalmologists and, 926—E
ORANGE Ex-O Digestant and Tonic, 64—BI
grapefruit (Dromedary), 293; 383
juice, (Hale's Pride) 923; (Absopure) 1009
juice, vitamin C excretion after, [Hawley] 1604—ab
ORBIT, implantation of gold sphere in Tenon's space, 2181
ORCHESTRA, physicians', (Wayne County) 1015; (Philadelphia) 1400
ORCHITIS: See Testis inflammation
OREGON Academy of Ophthalmology and Otolaryngology, graduate course, 714
ORGANS, processes of endocrine origin, 310
Sex: See Genitals
years after injecting thorium dioxide, [Naegeli] 2114—ab
ORIEL'S P Substance: See Anaphylaxis and Allergy, treatment
OROPHARYNGITIS, membranous, [Hiller] 579—ab
ORTAL Sodium, Kapseals, with Phenacetin, 1661
ORTHOPEDICS, conditions, heat in, [Gill] ★40
mechanic wanted for Canal service, 1325
National Congress of, Italy, 721
surgery, American Board of, (examination) 547; 1578
treatment in schools, England, 636
OSCILLATING Bed: See Bed
OSCILLOGRAPHS, use, 404
OSMOSIS, reduction in colloidal osmotic pressure of blood serum, [Torbert & Cheney] ★683
OSSIFICATION: See Calcification (cross reference); Calcinosis; Fontanels; Myositis
OSTEARTHRITIS: See Osteo-Arthritis
OSTEITIS deformans, experimental Paget's disease, [Moehlig] 75—ab
deformans, Paget's and Recklinghausen's diseases, [Mandel] 581—ab
deformans, Paget's disease and parathyroids, 1566—E
fibrosa cystica (generalized) [Jessop] 2110—ab
fibrosa, hyperparathyroidism, [Wilder & Howell] ★427
OSTEO-ARTHRITIS, blood in, [Hartung & others] ★1448
chronic, 644
of hip and knee, 137
of spine, 941
protein studies in, [Davis] 1233—ab

OSTEOCHONDRITIS dissecans as related to trauma, [Funsten] 1690—ab
OSTEOGENESIS Imperfecta: See Bones fragility
OSTEOMALACIA: See Bones, softening
OSTEOMYELITIS, acute, immediate vs. late operation in, 2081
chronic, skin grafting after saucerization for, [Armstrong] 2195—ab
fistula, silver nitrate sticks for, [Freund] ★1268
Gill bone block operation for foot drop, [Wheeldon & Clark] ★441
gummatous acute, [Mandelbaum & Saperstein] ★1061
hematogenous acute, in children, [Wilson] 2195—ab
of infants different from that of older children, [Green] 1601—ab
of jaw treated with staphylococcus anatoxin, 1403
OSTEOPATHS, Judicial Council report on association with cults, 1197
examined by state boards, ★1478
Practice Acts: See under Medicolegal Abstracts at end of letter M
registered by state boards, ★1485-★1488
OSTEOPOROSIS, sympathectomy, [Adson] ★363
OTITIS MEDIA, acute, and swimming, 2178
OTOLARYNGOLOGY, course in, Paris 932
Oregon Academy of, graduate course, 714
physiologic approach to, [Fenton] ★1775
OTOSCLEROSIS, possibility of pregnancy exaggerating, 1841
OUTPATIENT department, use in medical education, [Marriott] ★1442; (discussion) [Keeton & others] 1500—ab
obstetrics, [Buxbaum] 1761—ab
OVARY, cyst (huge), rapid growth, [Moolten] ★114
function, recrudescence after irradiation, [Smith] 2106—ab
grafts, use, 869
hormones relation to chronic mastitis, [Taylor 1606—ab
inflammation, oophoritis parotidea (Osler), [Ohlmacher] ★2053
irradiation, in breast cancer, 944; (reply) [Simmons] 1515; [Hill] 1940
transperitoneal migration, [Posatti] 1863—ab
tumor, causing masculation, [Schiller] 965—ab
tumor, dysgerminoma, [Fauvet] 1863—ab
OXALIC ACID: See Acid; Urine
OXFORD University Provident Association, medical plan for undergraduates, 134
OXIDATION: See Tissue
OXYACETYLENE welding, industrial hazards, 1590; 2090
OXYCEPHALY, [Klein] 2105—ab
OXYDASE, ferments of raw vegetables and digestion, [Matvieeff] 1134—ab
OXYGEN colon irrigation in amebiasis, [Golob] ★1725
effect of increased pressure on epilepsy, 2073—E; [Lennox] 2104—ab
effects of, at pressure of 3 atmospheres, [Behnke] 1038—ab
Inhalations: See Alcoholism: Pneumonia
Injection: See Joints; Tuberculosis, Pulmonary, treatment
tent, McKesson, 1987
treatment, necessity of prescribing dosage and testing concentration, [Barach] 725—C
treatment, New York Academy memorandum, 2188
OXYTOCIC Principle: See Labor; Pituitary, posterior, extract

P

PACIFIC Northwest Society of Pathologists organized, 474
PACINI, FILIPPO, commemoration of Italian anatomist, 721
PACKAGE: See Labeling
PAD, Heating: See Altherm Sinus Pad
PAGET'S DISEASE: See Osteitis deformans
PAIN: See also Abdomen; Arm; Breast; Coccyx; Extremities; Gallbladder surgery; Pleura; Precordium: Rectum; Shoulder
diagnosis in traumatism, 1676
paroxysms with numbness of thumb, 316
production, rôle of autonomic system, [Davis] & Pollock] ★350
referred, sacrarthrogenetic telalgia, [Pitkin] 741—ab
Relief of: See also Cancer; Eyes; Pelvis
relief of, alcohol intraspinally for, [Russell] 2202—ab
relief of, bilateral chordotomy for, 549
relief of, operations on sympathetic in, [Adson] ★365
relief of, roentgen rays for, [von Mészöly] 751—ab
relief of, safe analgesics, 1682
PAINT, poisoning from, 238
PALATE: See also Nasopalatine Duct
cleft, hereditary nature, 58
cleft, operation for, [Browne] 746—ab
PALPATION: See Abdomen
PALSY, Bell's: See Paralysis, facial
PANCOAST Tumor: See Tumor
PANCREAS, adenocarcinoma, enzyme content, [Sugiura] 1419—ab
cancer, diagnosis, [Sones] 1232—ab
cancer of head, surgical treatment, [Judd] 333—ab
compensatory hypertrophy in pregnancy protects fetus, 136
disorders, secretin diagnostic test, [Chiray] 2035—ab
function in diabetes mellitus, [Barbera] 964—ab
function test, [Berger] 2205—ab
insular emaciation, [Liegner] 424—ab
necrosis (acute), [Grønn] 1240—ab
raw or dried, in diabetes, [Barbera] 964—ab
PANCREATIN, effect of alcohol on digestion by, [Biotner] ★1970
PANCREATITIS, acute, in childhood, [Dobbs] 164—ab
chronic, or adrenal tumor, 1412
PANCREOTOXIN: See Diabetes Mellitus treatment
PANEL Practice: See Medicine, practice
PAPAVERINE Treatment: See Embolism: Thrombosis
PAPER industry (wood), dermatoses in, 315
mill, injurious effect of chlorine (bleach gas) in, 2024
PARABIOSIS: See Genitals
PARABOLOID Condenser: See Microscopy
PARACELSUS, 143—BI
PARACOCCIDIOIDES brasiliensis granuloma, [Jordon] 740—ab
PARALYSIS: See also Hemiplegia; Intestines, paralytic ileus
after subarachnoid alcohol injection, 1115
agitans, diagnosis, spinal fluid changes in, 645
agitans (Parkinson's syndrome), hyperthermia, 874
deltoid, traumatic, muscle transplantation for, [Davidson] ★2237
diphtheria toxoid not followed by, 403
effect of lumbar sympathectomy on growth of paralyzed legs, [Harris] 741—ab
facial and brachial, as birth injury, [Galloway] ★506; ★507
facial, Bell's palsy, treatment, 727; (reply) [Titus] 1333
facial, traumatic, stellate ganglionectomy in, [Caeiro] 1611—ab
Infantile: See Poliomyelitis
Ischemic: See under Medicolegal Abstracts at end of letter M
Landry's, changes in type, [Tanaka] 1419—ab
obstetric, of shoulder, 721
of axillary (circumflex) nerve with spontaneous recovery, [Hirsch] ★705
of foot, etiology, 2090
peripheral radial, in new-born, [Krafft] 259—ab
spastic child, problem of, [Brockway] ★1635
spastic (Little's disease), static infantilism in, [Flusser] 583—ab
spastic, treatment, 728
treatment, underwater exercises, [Scholtz] 1772—ab
PARALYSIS, GENERAL, of insane, diathermy fever for, [Epstein & others] ★1527
of insane, hyperglycemia and, [Blackford] 1044—ab
of insane, hyperpyrexia for, 1680
of insane, possible, 1756
of insane, 10 years of malaria therapy, [Hutchings] 959—ab
PARAMYTONIA congenita (Thomsen's disease), [Schott] 342—ab
PARASITES: See Gordius robustus
PARATHYROID, and bone diseases, 1566—E
extract, induced hypercalcemia, [Lowenburg & Ginsburg] ★1779
hyperparathyroidism, 1214
hyperparathyroidism, etiology; diagnosis, [Wilder & Howell] ★427
hyperparathyroidism, hypercalcemia and hypophosphatemia simulate, [Birk] 745—ab
hyperparathyroidism, roentgen changes, [Camp] 2198—ab
hyperplasia and vitamin D, [Quick] 871—C
hypoparathyroidism, calcium in diet vs., [Cazzamali] 883—ab
injections, magnesiemia after, [Melli] 165—ab
new anatomic concept, [Herrman] ★1357
relation to chronic arthritis, [Wootton] 1854—ab
relation to urinary lithiasis, [Barney] 2109—ab
surgery, 1405
surgery and calcium metabolism, [Mandl] 581—ab
surgery, excision in ankylosing polyarthritis, [Fedorov] 2268—ab
Therapy: See Colitis ulcerative
PARATHYROIDECTOMY: See Parathyroid surgery
PARATYPHOID B group, type diagnosis, [Hallauer) 963—ab
diagnosis (serologic), rapid slide test for, [Welch] 1762—ab
diagnosis, systemic salmonella infections simulating, [Wu] 1046—ab
PARENT: See also Maternal; Paternity
age of, relation to deficiencies of offspring, [Kleindienst] 502—ab
PAROLE Clinic: See Hospitals, psychiatric
PAROTID GLAND, abnormal diastase values and blood sugar content, [Jorns] 1237—ab
PAROTITIS, etiology, 56
meningitis in mumps, [Silwer] 1958—ab
orchitis and oophoritis parotidea (Osler), [Ohlmacher] ★2053
polyneuritis after (rare), 867
PARROTS: See Psittacosis
PASSIVE Vascular Exercise: See Blood Vessels, disease
PATCH Test: See Skin test
PATELLA, fractures of, [Blodgett & Fairchild] ★2121
PATENT MEDICINES: See Nostrums
PATENTS: See also Scarlet Fever; Tryparsamide
A. M. A. Judicial Council decision, 1196
scientific discoveries and, 1388—E
PATERNITY, blood tests for, [Smith] 559—C
M and N factors in erythrocytes, [Blinov] 343—ab
PATHOLOGISTS, Pacific Northwest Society of, organized, 474
PATHOLOGY, Comparative, third Congress of, Athens, 1106
Departments: See Hospitals
dermatology field for those interested in, 1214
Laboratory of: See Laboratory, clinical
of identical twins, 1568—E
Sociedad de Patologia reunion, 1510
PATIENT, evaluation of individual constitution, 639
physician relationship, [Shurly & Bullock] ★298
PATRIZI, LUIGI MARIANO, death, 310
PAVAEX: See also Blood Vessels diseases
improved cuff for, [McKelvey] ★920
Unit (Passive Vascular Exerciser), 1986
PAVLOV, IVAN PETROVITCH, death, 858—E; 864; 1833
PEACOCK'S Bromides, coma of 4 months' duration from, [Craven & Lancaster] ★1383
PEACOCK, SILBER C., murdered on fake call, 220; 1208
PEANUT Butter, Skippy Improved, 215
PEARCE-BROWN Epithelioma: See Epithelioma Tumor: See Tumor
PEARLS of Wheat, 1009
PEAS, Cellu Brand, 1809
PEDIATRICS, American Academy of, 1578
American Board of, certification, 223
Berlin Society, 309
graduate courses in, federal funds for, Wisconsin, 1827; 2077
need of, in training physicians, 397
preventive, International Association for, fifth conference, 718
sex ratio in children's diseases, [Bonell] 752—ab
PEEL: See Skin
PELEGRINI-STIEDA Disease: See Köhler
PELLAGRA, anemia of, [Spies] 78—ab
electrocardiograms and cardiac systole in, [Feil] 1229—ab
in the adult, [Haden] ★261
PELLISSIER, H., death, 1406
PELVIS, contracted, bone graft to increase, 2017
fibrosclerosis, 1750
inflammatory conditions, rectal therapy, [Shpolyanskiy] 169—ab
inflammatory disease, estrogenic substances for, [Fluhmann] 1426—ab
joint relaxation in pregnancy, [Thoms] ★1364
obstruction (noncalculous ureteropelvic), [Harris] 418—ab
pain in women, superior hypogastric plexus resection for, [Kindel] 738—ab
pain (intractable), presacral nerve resection for, [Bailey] 339—ab
shape of, correlation with labor, [Pettit] 960—ab
surgery, localized swellings after, 485
tumors, differential diagnosis, [Gough] 79—ab
PEMPHIGUS neonatorum, [Carter] 2199—ab
PENIS, cancer, inguinal gland metastases, [Barringer] ★21
dermatitis from ephedrine, [Hollander] ★706
plastic induration, 2020
PENSIONERS, war, England, 54
PENTNUCLEOTIDE: See Leukopenia, treatment
PEPPERMINT, oil of, effects, 1224
PEPPERS, home canned, botulism outbreak from, New Jersey, [Caprio] ★687
PEPSIN, effect on healing of gastric defects, [Howes] 1045—ab
gastric secretion in various diseases, [Mullins] 77—ab
removal in stomach preparation for pernicious anemia, [Greenspon] ★266; 295—E; [Hanes & others] ★2058
PEPTIC ULCER, cancer of duodenum relation to, [Startz] 745—ab
complications, bradycardia, 1746
diagnosis of activity, Marks precipitin test for albumin, [Marks] 412—ab, 1848—ab
diagnosis of allergens causing, leukopenic index for, [Gay] ★969
diagnostic errors in gastric, [von Haberer] 502—ab

PEPTIC ULCER—Continued
diagnostic importance of distant symptoms in gastroduodenal, [Diefenthaler] 1237—ab
duodenal, alterations, [Ruckensteiner] 1048—ab
duodenal, with erythremia, [Kraemer] 1123—ab
gastric, relation to gastritis, [Derman] 2116—ab
gastric, with fatal hemorrhage in new-born, [Kunstadter & Gettleman] ★207
gastroduodenal, role of curvature of spine, [Pines] 425—ab
jejunal, [Judd] 418—ab
perforation of gastric duodenal, [Yudin] 1137—ab
perforation of gastric; surgical results, [Häussler] 1612—ab
postanastomotic, 2251
prepyloric (benign) [Singleton] 1605—ab
secretion of gastric mucin in, [Anderson] 1603—ab
surgical risk, weight loss as indicator, [Studley] ★458
surgical treatment of chronic duodenal, [Lewisohn] ★684
surgical treatment of gastroduodenal; gastric acidity after, [Walters] 413—ab; [Paggi] 1611—ab
treatment, alkali, renal insufficiency from, [Steele] ★2049
treatment, aluminum hydroxide drip to control acidity, [Woldman] 1338—ab
treatment, based on physiologic principles, [Ochsner] 1425—ab
treatment, diet, of hematemesis and melena, [Meulengracht] 660—ab
treatment, dietetic, in diabetics, [Lampé] 503—ab
treatment, gastroduodenal, [Abrumyants) 84—ab
treatment, histidine monohydrochloride (Larostidin), [Volini] 956—ab; [Wilhelmy] 1339—ab; [Sandweiss] ★1452; [Martin] ★1468; (Council report) 1473
treatment, hydrated magnesium trisilicate, [Mutch] 1858—ab
treatment, powdered milk and alkali, [Wosika] 1421—ab
treatment, shock, by injecting heterogenous blood intravenously, [Ryss] 1694—ab
twin (kissing) ulcers, [Ruckensteiner] 1048—ab
urinary retention, intestinal atony and hemorrhage from, [Melchior] 1433—ab
why is achylic stomach with ulcer free from pain, 1028
PERFORATION: See Nose, septum; Peptic Ulcer; Typhoid
PERFUMES, lip stick dermatitis; methyl heptine carbonate, 470—E; [Landsteiner & Jacobs] 1112—C
PERIARTERITIS nodosa, new clinical syndrome, [Horton] 246—ab
nodosa, unusual features; recovery, [Motley] ★898
PERICARDIECTOMY: See Pericarditis
PERICARDITIS, chronic mediastinal, 396
constricting, pericardiectomy relieves; roentgenkymogram, [Griswold] ★1054
suppurative, posterior drainage in, [Moore] 417—ab
PERICARDIUM, puncture, epigastric subxiphoid route, [Marfan] 1955—ab
PERINEUM excoriation from silver wire sutures, prevention, [Grad] 570—ab
insertion of sutures before laceration in childbirth, 2094
testicle in, [Campbell] ★2232
PERIODICALS: See Journals
PERIODONTOCLASIA: See Pyorrhea
PERITONEUM: See also Pneumoperitoneum
Hemorrhage: See Abdomen hemorrhage
immunity, amniotic fluid concentrate as activator, [Johnson] 1045—ab
immunization to lower operative mortality, [Herrmann] 881—ab
washing cavity with physiologic solution of sodium chloride, 2256
PERITONITIS, "general," 224
pneumococcic, [Schaanning] 170—ab
pneumococcic, in infants (rare), [Diaz Bobillo] 1611—ab
PEROXYDASE in raw vegetables and digestion, [Matvieeff] 1134—ab
PERSPIRATION: See Sweating
PERTUSSIS: See Whooping Cough
PE-RU-NA Tablets, 143—BI
PESSARIES, Gellhorn and Menge, for uterus prolapse, 67
PETROLATUM, liquid, advantages and ill effects in constipation, 66
PETROSITIS, acute suppurative, preoperative ventricular puncture, [Rosen] 1040—ab
PETT'S Salve, 64—BI
PEVELY Evaporated Milk, 467
PEZZAR Catheter: See Empyema
PHAGOID Laboratories, Inc., preparations, 922
PHARMACISTS: See also under Medicolegal Abstracts at end of letter M
druggist treats everything, [Schwartz] 871—C
women, Germany, 2082
PHARMACOLOGY, essential, of autonomic nervous system, [Jackson] ★357
PHARMACOPEIA, U. S., epitome, 1171
PHARMACY Practice Acts: See under Medicolegal Abstracts at end of letter M
leasing, regulations, Germany, 1932
PHARYNX: See Oropharyngitis
PHASE (Impedance) Angle Test: See Hyperthyroidism
PHENACETIN, Compressed Tablets Sal-Ethyl Carbonate with, 2239
Kapseals Ortal Sodium with, 1661
PHENOBARBITAL, effect of long continued use, 564
effect on blood count, [Wilson] 420—ab
improved sedative, [Robinson] 419—ab
poisoning (fatal) from luminal [Scarlet] 497—ab
theobromine preparation, effect on coronary circulation, 1593
thrombocytopenic purpura after, [Boas] 1952—ab
Treatment: See Migraine
PHENO-ISOLIN, 724—BI
PHENOL, tetrachlor sodium, eruptions in lumber workers from, 2092
antiemetic combination, 2256
Treatment: See Extremities diseases
PHENOLPHTHALIN Test: See Blood, occult
PHENYLMERCURIC nitrate, therapeutic use, [Biskind] 340—ab
PHILADELPHIA College of Pharmacy and Science, 546
County Medical Society graduate institute, 390
Strain: See Influenza virus
PHILIPPINES, medical progress in, 1497—E
PHILOSOPHY of life, Haldane's, 1671
PHLEBITIS: See also Thrombophlebitis
after gonorrhea, 647
prevention in gynecologic surgery, [Cotte] 423—ab
preventive treatment, pedaling the "bed bicycle," [Dalsgaard] 1138—ab
treatment, 1755
treatment, procaine infiltration of lumbar sympathetic, 56
treatment, venous ligations, [Napalkow] 1955—ab
PHLYCTENULAR DISEASE and vitamin deficiency, [Redding] 499—ab
PHOSPHATASE in Blood: See Blood
PHOSPHATE ions, concentration, rôle in calcification mechanism, 384—E
PHOSPHORUS, burns, treatment, [Starz] 884—ab
dietary calcium and, 2161—E
in Blood: See Blood
PHOTOGRAPHY cystoscopes, 1515
sensitivity to solutions, 1028
PHRENICECTOMY: See Nerves
PHRENICOTHLASTY: See Tuberculosis, Pulmonary
PHYSICAL CONDITION and unemployment, 46—E
PHYSICAL DEFECTS, A. M. A. resolution on mechanical aids for, 1913; 1922
PHYSICAL EDUCATION: See also Athletics; Exercise
in schools, England, 636; 866
need for, committee report, England, 2079
PHYSICAL EXAMINATION for German army service, 2171
lawful authorization, [Woodward] ★33
prenuptial, 397
regular, in industrial plants, 227
PHYSICAL MEDICINE, International Congress (sixth), 1506; 1745; (Lord Horder's address) 1745
PHYSICAL THERAPY: See also under names of specific diseases
American College of, 239
American Congress of, 547; 2078
apparatus, consideration by Council, 1174
department dedicated at U. of Michigan Hospital, 1503.
technicians, registry, 1174
technicians, schools for, essentials proposed by A. M. A., 1819; 1904
PHYSICIANS: See also Economics, Medical; Education, Medical; Ethics, Medical; Licensure; Malpractice; Specialists; Surgeons; etc.
A. M. A. resolution on unethical listing in commercial directories, 1823; 1921
advertising, newspaper bars, N. Y., 2013
altruism of, reply to Laski, [Shurly & Bullock] ★297
American College of, 635
association with cults, Judicial Council report, 1197
attitudes by groups toward A. M. A. policies, [Mason] 1817
avocations, art, (Haden Etching Club, New York) 131; (New York Physicians Art Club) 714; 1504; (Physicians Art Society, Boston) 1015
avocations, hobby exhibit, Chicago, 220; 1824
avocations, orchestra, (Detroit) 1015; (Philadelphia) 1400
Deaths of: See also List of Deaths at end of letter D
deaths of, high mortality of Viennese, 1329
deaths of, published in 1935, 1389—E
Declaration of Independence signed by, 2235—ab
freedom of choice of, and sickness insurance, (Austria) 2172; (Italy) 2251
PHYSICIANS—Continued
freedom of choice of, in industrial medicine, [Bloom] ★1991
Graduate Courses for: See Education, Medical
Guide for Belgian physicians, new edition of, 397
Heroes: See Heroes
in public medical service, Rumania, 1832
Income Tax: See Tax
Jewish: See Jews
law (new state), Germany, 551; 1509
Martyrs: See Martyrs
meet with legislators, Massachusetts, 1101
Membership in Societies: See Societies, Medical
Nature Cure: See Nature cure
offices, flood waters in, Pittsburgh, 1505
official, gradation, Bucharest, 480
patient relationship, [Shurly & Bullock] ★298
personal endorsement signatures, 1807
Practicing: See also Medicine, practice; Medicine, profession
practicing, 85 per cent need general practitioner, [Bierring] 1097—ab
problems, Italy, 2251
receiving The JOURNAL, 1169
Rumanian, compulsory graduate courses, 481; 1832
social objective of young physician, [Van Etten] ★772
specializing in radiology, ★618
supply, distribution, U. S., 1181
supply in rural communities, Bureau of Medical Economics questionnaire, 1914; 1916
supply, increase, Japan, 1217
supply, licentiates representing additions, U. S., ★1483
supply, rural districts, (Rumania) 720; (U. S.) 1913; 1919
Swiss Physicians' Old Age and Life Insurance Society, 2084
Taxation: See Tax
tuberculosis sanatorium needs, Wisconsin, 2167
United States government positions open for, (U. S. Public Health Service) 391; 2167; (U. S. Air Corps Laboratory) 932; (CCC) 1212
Veteran: See also under names specific persons as Béclère; Evans; Freud; etc.
veteran, care for, Austria, 374
women, Germany, 2082
PHYSICS, Clinical, Institute of Argentine, 1510
PHYSIOLOGIST wanted for U. S. Air Corps laboratory, Dayton, 932
PHYSIOLOGY, approach to otolaryngology, [Fenton] ★1775
PHYSOSTIGMINE Treatment: See Myasthenia gravis
PIGEON Toes: See Metatarsus
PIGMENTATION: See also Dermatitis, purpuric; Hair; Nevus, pigmented; Skin
sunlight and nutrition, 218—E
PILES: See Hemorrhoids
PILLS: See Drugs
PILOCARPINE: See also Morphine addiction
effect on emptying time of stomach, [Herrin] 1762—ab
PILOTS: See Aviation
PINEAL GLAND extract (Hanson), biologic effects, [Rowntree & others] ★370
tumor, observations on, [Horrax] 1125—ab
PINEAPPLE, Hawaiian, brands accepted, 215; 707; 923; 1166; 1387; 1565
juice (canned), vitamins in, [Guerrant] 2196—ab
juice, Hawaiian, brands accepted, 293; (Cellu) 539; 1661
PINK DISEASE: See Acrodynia
PISTOR, ADOLPH J., meat inspection chief dies, 716
PITOCIN: See Pituitary, posterior
PITRESSIN, effects on blood pressure and intestinal activity, [Melville] ★102
Ampoules of Pitressin (P. D. & Co.), potency, Council report, 382
PITUITARY, anterior, adrenotropic hormone, [Raab] 664—ab
anterior, antagonizes insulin, [Collens & others] ★678
anterior, chronic mastitis relation to, [Taylor] 1606—ab
anterior, disease, adiposogenital dystrophy, 237
anterior extract treatment of gastric hypotonia, [Curschmann] 166—ab
Anterior Hormone (gonadotropic): See Gonadotropic Principles; Pregnancy urine extract
anterior, species differences in, chemical modification, 45—E
anterior thyrotropic hormone, induction of refractory state, [Bruner & Starr] 248—ab
anterior thyrotropic principles, in therapy of myxedema, [Schneiderbaur] 168—ab
basophilism, [Kraus] 583—ab; 775—ab
blood pressure regulation by, [Kylin] 342—ab
cachexia (Simmonds'), anterior pituitary liquid and Progynon-B cures, [Dunn] 1042—ab
cachexia (Simmonds'), with thyroid and adrenal insufficiency, [Rose] 1852—ab
diabetes mellitus and, [Anselmino] 585—ab; [Effkemann] 1862—ab
extracts, hypersensitiveness to, [Simon & Ryder] ★512

PITUITARY—Continued
function, estrogenic substance suppresses, [Collens & others] *678
hormone content vs. light and darkness, [Jores] 502—ab
hypophysectomized animals exposed to reduced atmospheric pressure, [Meyer] 325—ab
hypophyseothyrogenic adiposity and emaciation, [Wahlberg] *1968
insufficiency, low basal metabolic rate, [Berkman] *2045
insufficiency, metabolic studies, [Bulger] 1851—ab
insufficiency, obesity, 1681
insufficiency, striae distensae symptom in young men, [Schilling] 1238—ab
integration of endocrine system, [Langdon-Brown] 579—ab
irradiation for hypertension, [Hutton] 1040—ab; [Hutton & others] 1753—C; (reply) [Rogoff] 1753—C
irradiation for menstrual disorders, [Wittenbourg] 1525—ab
irradiation in breast cancer, [Hill] 1940
posterior, and insulin, [Ellsworth] 2197—ab
posterior (dry and powdered) for diabetes insipidus, [Hanssen] 884—ab
posterior extract, antidiuretic principle, [Heller] 748—ab
posterior extract in angioneurotic disorders, [Klein] 424—ab
posterior extract, pressor and oxytocic fractions (pitocin & pitressin; postlobin-V and postlobin-G), [Melville] *102
tumor, adenoma (basophilic), 775—ab
tumor, adenoma (subclinical), [Costello] 1849—ab
tumor, produced by painting skin with estrogenic substance, [Cramer] 1768—ab
PLACENTA, blood coagulant extract from, for hemophilia, [Eley] 1422—ab
Extract (Emmenin): See Estrogenic Substances
extract in control of German measles, [Gottlieb] 743—ab
fibrosis, [Montgomery] 1229—ab
Immune Globulin: See Measles, prevention
permeability to tuberculosis, [Lucksch] 1525—ab
praevia, 59
praevia, amniographic diagnosis, [Burke] 747—ab
theory of eclampsia, [Ulesko-Stroganowa] 965—ab
tissue as antigen used in Gruskin intradermal test, [Gruskin] 953—ab
Tumors: See Chorionepithelioma
PLAGUE bacillus, murder by, 933
-infected ground squirred, California, 1739
PLANTS: See Chlorophyll
PLAPAO Laboratories, Inc., 557—BI
PLASMA: See Blood fibrin
Cholesterol: See Blood
PLASMOCHIN Treatment: See Malaria
PLASTER: See Adhesive
PLAS-TR-PADS, 557—BI
PLATES, Dental: See Teeth
PLEURA adhesions in pulmonary tuberculosis, [Drash] 1607—ab
adhesions, nervous complications from freeing, [Mistal] 1429—ab
cirrhosis, diagnostic sign, [Mura] 165—ab
complications of amebiasis, [Ochsner] 1522—ab
conglutination, effect on heart, [Korns] 324—ab
effusion, incidence in artificial pneumothorax, [Rosenthal] 1608—ab
effusions (simple), 3 zones, [Kaunitz] 1039—ab
Hemorrhage: See Pleurisy hemorrhagic
Irradiation: See Empyema
pain, artificial pneumothorax to relieve, [Shaw] 882—ab
pressure (high intrapleural), effect on blood pressure, [Head] 159—ab
pressure (intrapleural), 1222
shock; effusions complicating pneumothorax therapy, [Cutler] *1371
PLEURISY, hemorrhagic, of tuberculous origin, [Korol] 1124—ab
pathogenesis during bilateral pneumothorax, 1933
rheumatic, [Starr] 74—ab
PLEURODYNIA: See Myositis, epidemic
PLOTZ Foundation: See Foundation
PLUMMER'S Treatment: See Goiter, Exophthalmic
PLUMS, Cellu Prune, 467
PNEUMATIC Tools: See Air, compressed
PNEUMECTOMY: See Lungs cancer
PNEUMOCOCCUS, Antipneumococcic Serum Types I and II Refined and Concentrated, 1565
Meningitis: See Meningitis
Peritonitis: See Peritonitis
Pneumonia: See Pneumonia
Refined and Concentrated Antipneumococcic Serum Type VII-Lederle, 1564; (correction) 2150
toxins, [Coca] 957—ab
typing (rapid) by Neufeld reaction, [Vinograd] 2261—ab
typing stations established, Maine, 1399
PNEUMOCONIOSIS; asbestosis, [Lanza] *368
roentgen shadows in, [Sweany] *1959
silicosis an occupational disease? 1672
silicosis, committees to study, U. S., 1828
silicosis investigated by U. S. Congress, 1176; 1180
silicosis, "tripoli" as source of, [McCord] *913
PNEUMOMEDIASTINUM, artificial, [Condorelli] 1047—ab
PNEUMONECTOMY: See Lungs, cancer
PNEUMONIA: See also Bronchopneumonia; under Medicolegal Abstracts at end of letter M
atypical, question, [Cass] 1129—ab
Commonwealth Fund study, 221; 2258
control program (Michigan) 303; (New York) 546
diagnosis, early, 1965—ab
diastasuria in, [Pavel] 967—ab
erythrocyte fragility in, [Needles] 955—ab
lobar, galactose liver function test, in galactosuria, [Canali] 1135—ab
lobar, lung puncture in, [Sappington] 1123—ab
macrophage system of lungs in, [Robertson] 742—ab
problems created by floods, 1092—E
reaction to pneumococcus toxin, [Coca] 957—ab
recurrence in childhood, [Greene] 1420—ab
treatment, alcohol intravenously, [Bakhsh] 961—ab
treatment, antipneumococcic serum, types I, II and VII, 1564; 1565; (correction) 2150
treatment, Felton's serum and diathermy, 872
treatment, insulin and carbohydrate, [Sinelnikov] 259—ab
treatment, new (Lilly) heterophile (Forssman) antipneumococcus serum, [Thompson] 324—ab; [Noble] 2106—ab
treatment, oxygen inhalations, [Kurshakov] 260—ab
treatment, pneumothorax, [Abernathy] 880—ab; [Blake] 1853—ab
treatment, pneumothorax, lung volume during, [Lindskog] 1848—ab
treatment, quinine-calcium, [Raue] 751—ab
type specificity in, [Kohl & Reitzel] *1557
PNEUMONOCONIOSIS: See Pneumoconiosis
PNEUMOPERITONEUM in intestinal tuberculosis, [Salkin] 2102—ab
PNEUMOTHORAX: See Hemopneumothorax; Hydropneumothorax; Pyopneumothorax
PNEUMOTHORAX, ARTIFICIAL: See also Pleura, pain; Pneumonia, treatment; Tuberculosis, Pulmonary, artificial pneumothorax in
adhesions in, [Ellison] 330—ab; [King] 337—ab
disinfectants in, [Müller] 750—ab
effect in epilepsy, [Slivko] 260—ab
effect on electrocardiogram, [Natin] 883—ab
gases, composition, 136
hemiplegia after, 135
pleural effusion in, incidence, [Rosenthal] 1608—ab
POISON: See under Medicolegal Abstracts at end of letter M
Ivy: See Rhus
POISONING: See also Barbital; Bromide; Carbon Monoxide; Lead; Nicotine; Potassium; etc.
Food: See Botulism; Food
Industrial: See Industrial
safeguards against, 1745
POLIO-ENCEPHALITIS, after spinal anesthesia, [Brock & others] *441
POLIOMYELITIS epidemic, summary, Kentucky, 220
experimental, resistance; immunity, [Hudson & others] *2037
experiments with, 720
infection (respiratory vs. gastro-intestinal) [Flexner] 1041—ab
limber neck of chickens relation to, 1027; (reply) [Murray] 1682
prevention by intranasal route, [Peskind] 483—C; [Armstrong] 1424—ab [Hudson & others] *2037
prevention, France, 2249
recent studies on, 708—E
simulating trichiniasis, [Merritt & Rosenbaum] *1646
spinal fluid test, 2254
treatment, Gill bone block operation for foot drop, [Wheeldon & Clark] *441
treatment, lumbar sympathectomy effect on growth of paralyzed legs, [Harris] 741—ab
treatment, sympathectomy, [Adson] *363
treatment, underwater therapy for the crippled, 478
vaccination, warning, 1831
vaccines prohibited, 219
virus, seventh nerve as pathway, [Toomey] 879—ab
POLISHING chrome plate and enamel compacts, industrial hazard, 1681
POLLEN extract (ragweed), active substance in, Prausnitz-Küstner reaction, [Caulfeild] 334—ab
filtration, air filters used for, to relieve hay fever, 1940
in Alpena, Mich., (reply) [Durham] 239
Kaiseraire Filter Ventilator, 1731
POLYARTHRITIS: See Arthritis
POLYCYTHEMIA, complicating duodenal ulcer, [Kraemer] 1123—ab
diagnosis, leukemia with thrombocytosis? [Dameshek] 1837—C
experimental, antianemic treatment in, [Marshall] 571—ab
splenomegalic, and pernicious anemia, [Baráth] 752—ab
vera, carbonic anhydrase content of blood, [Hodgson] 1857—ab
POLYNEURITIS: See Neuritis
POLYPS, diffuse, of large intestine, [Nyström] 426—ab
gastric, [Van Buskirk] 2195—ab
gastro-intestinal, malignancy incidence, [Lawrence] 1420—ab
of colon, [Hardy] *910
pathology of rhinosporidiosis, [Karunaratne] 1428—ab
PONS VAROLII, abscess, [Lichtensein & Zeitlin] *1057
POOR, problem of diet, England, 1213
Medical Service for: See Medical Service for the indigent
POPULATION: See also Rural population
English, changes in, 717
of Vienna, 478
PORK: See Trichinosis
PORPHYRIN, in lead poisoning, [Carrié] 1237—ab
in Urine: See Urine
PORTAL VEIN, Talma's operation, [Henningsen] 1612—ab
PORTMANN, GEORGES, course by, 306
POSITION: See Posture
POSTGRADUATE Courses: See Education, Medical
POSTLOBIN-O; POSTLOBIN-V: See Pituitary, posterior
POSTMORTEM Examination: See Autopsies
POSTURE, cardiac output in standing position, [Scott] 2191—ab
changes insured, by motorized oscillating bed, [Sanders] *916
correction, 563
effect on blood pressure, test for measuring, [Brown] *354; *356
effect on partial heart block, [Alexander] 1229—ab
in arterial hypertension, 873
pulmonary rest by, [Pierson] 738—ab
spectacles for those forced recumbent, 71; (adv. page 26, Jan. 11,'36 issue)
POTASSIUM chloride, effects of excessive ingestion, [McQuarrie] 1043—ab
ferricyanide test of urine sugar, [Gugliucci] 1860—ab
iodide, administering so as to avoid aftertaste, 1591
permanganate poisoning, [Willimott] 1608—ab
salts, action; excretion by kidney, [Keith] 415—ab
Tartrate: See Lymphogranuloma inguinale
Thiocyanate: See Blood Pressure, high
POTATO famines and scurvy, 1894
POVERTY: See Poor
PRACTICE of Medicine: See Medicine; Physicians, practicing
PRAUSNITZ-KÜSTNER Reaction: See Pollen extract
PRECIPITIN Test: See Albumin; Streptococcus, hemolytic
PRECORDIUM, pain from cervical arthritis, [Hanflig] *523
stab wound, 2183
PREECLAMPSIA: See Eclampsia
PREGNANCY: See also Abortion; Eclampsia; Embryo; Fetus; Impregnation, artificial; Labor; Maternal; Obstetrics; Puerperal Infection; Puerperium
after sloughing of cesarean uterine sutures, [Fist] 1331—C
alopecia during, 944
Anemia of: See Anemia
blood in, hypercholesteremia, [Bartholomew] 2101—ab
blood pressure changes in, 2025
blood water concentration, [Oberst] 1037—ab
castor oil given as laxative late in, 1591
Complications: See also Pregnancy, syphilis in; Pregnancy, tumors complicating
complications, argyria, [Raaf & Gray] *916
complications, diabetes, [Reznitskaya] 1050—ab; [Kraus] 1955—ab
complications, diabetes, offspring well protected against, 136
complications, encephalitis (nonsuppurative), [Shafer] *699
complications, exophthalmic goiter, hyperthyroidism, [Bustos Morón] 81—ab
complications, fatal quinine hemoglobinuria with uremia, [Terplan & Javert] *529
complications, heart block, antisyphilitic treatment, [Bernstein] *532; [Greenhill] 872—C
complications, hypertension (essential), [Albrecht] 425—ab
complications, hypertension (idiopathic), 1029
complications, ileus (slight degree), [Yun] 1859—ab
complications, kidney necrosis (bilateral cortical), [De Navasquez] 339—ab
complications, tuberculosis, 1754
diagnosis, Bercovitz's ophthalmic method, 638

PREGNANCY—Continued
diagnosis, Gruskin intradermal test using placental tissue, [Gruskin] 953—ab
diagnosis, Kapeller-Adler test (histidine in urine), 2240—E
diagnosis, Konsuloff reaction, [Brühl] 664—ab
diagnosis, paranitro-anilinediazonium chloride to detect estrogenic substances in urine, [Schmulovitz] 335—ab
diagnosis, Visscher-Bowman chemical reaction, [Dolff] 504—ab
diet (salt-deficient) and, [Lambert] 83—ab
effect on skin manifestations; neurofibromatosis, [Sharpe & Young] ★682
extra-uterine (abdominal), hysterographic diagnosis, [Greenhill] ★606
extra-uterine, early and erroneous diagnosis, [Granzow] 750—ab
extra-uterine, transperitoneal migration of ovum, [Posatti] 1863—ab
gallbladder and bile during, [Potter] ★1070
hygiene, evening prenatal clinics, Chicago, 387
liver and, 394
metabolism during, [Hunscher] 574—ab; 1567—E
otosclerosis exaggerated by? 1841
respiration tests (Rosenthal, Flach, Monaldi, Gallois) during, [Marzetti] 501—ab
smoking during, effect on maternal health, [Campbell] 1761—ab
symphysis pubis relaxation in, [Thoms] ★1364
syphilis in, (Massachusetts) [Nelson] ★105; (treatment) 403; [Cole & others] ★464; (questionnaire) [Exner] ★488; (treatment) 872
toxemia, eye changes (ophthalmoscopic examination), [Hallum] ★1649
toxemia (late), 59
toxemia, low reserve kidney, [Peckham] 953—ab
tumors complicating, uterine fibroid, 1594
ureter physiologic changes in, [Traut] 659—ab
urinary tract changes in, [Hundley] 249—ab
Urine: See also Pregnancy diagnosis
Urine Extract: See also Gonadotropic Principles
urine extract, lactation ceases after injecting, [Sawizki] 259—ab
uterus, measurements, 1841
vaccination against puerperal infections, [Bernstine] 1037—ab
vitamin C requirements, [Neuweiler] 582—ab
PREMATURE Infants: See Infants
PRENATAL CLINICS: See Pregnancy hygiene
PRESCRIPTIONS: See also Cough treatment; Mental Disease; under Medicolegal Abstracts at end of letter M
incompatibility, 2093
writing and recent graduate, [David] ★405
writing, taxation on ground of, Bucharest, 480
PRESENTATION of Fetus: See Labor
PRESS: See also Newspaper
bureau, medical, Sedgwick County Medical Society, 1575
PRESSOR Fractions: See Pituitary, posterior, extract
Substance: See Blood Pressure
PRESSURE Dressing: See Dressings
Intrapleural: See Pleura
stimulus for, effect of smoking on, [Wenusch] 1773—ab
PRESTOLAS, 1837—BI
PREVENTIVE MEDICINE, survey of teaching, 2078
PRIVILEGED COMMUNICATION, new law extends professional secrecy, Germany, 867
PRIZES, A. M. A. recognition of fellows rendering distinguished service, 1912; 1921
American Institute's gold medal, 1014
Amory (Francis), 635
Argentine, awarded, 1510
Callahan-Memorial, 544
Capps, 2012
city health contest, 1670
Dana Medal, 2014
Gibbs Medal, 129
International Committees, for rhemuatism, 1833
Kober Medal, 1577
Massachusetts Medical Society, 1209
National Academy of Sciences, Public Welfare Medal, 2075
National Cuban Order of Carlos Finlay, 1209
New England Society of Psychiatry, 544; 1740
Nichols (William H.) Medal, 221
Palma, 1510
Phillips Medal, 1211
Procter Award, 546
Remington Medal, 1824
Ricketts (Howard Taylor), 1739
Society of American Bacteriologists, established, 132
Strittmatter award, 1669
Trudeau Medal, 1929
University of Buffalo Medal, 633
Wellcome, 548
PROCAINE Anesthesia: See Anesthesia
antagonistic to ephedrine, [Isenberger] 1951—ab
Hydrochloride, Ampul Solution, with Epinephrine, 1 cc., 782
PROCTOLOGY, American Society, 1323
PROETZ Displacement: See Sinusitis
PROFESSION, education and state university, [Willard] 1098—ab
German women in, 2082
of Medicine: See Medicine
PROFESSIONAL SECRECY: See Privileged Communications
PROGESTERONE, 1808
PROGESTIN, 1808
treatment of abortion, [Falls & others] ★271; 317
PROGYNON: See Estrogenic Substances
PROGYNON-B: See Estrogenic Substances
PROPANE, fatal inhalation of dichloropropane, [Gonzales] ★286
PROPRIETARIES, recent graduate and, [David] ★405
PROSTATE cancer simulating rectum malignancy, [Kickham] 1853—ab
congenital valve formation in prostatic urethra, [Aalkjaer] 1958—ab
hypertrophy, endo-urethral electrotomy for, [Wildegans] 2204—ab
hypertrophy, frequency of cancerigenic degeneration, 310
hypertrophy, frequency of urination with, 873
hypertrophy, use of inhibin (testis hormone), [Lower] 576—ab
hypertrophy with bladder rupture, [Scholl] ★701
massage, instruments (Eastman Masseur; Leusman) for, 874
obstruction (acute), temporary insulin resistance with, [Blaisdell] 1853—ab
resection, avoiding complications, [Bumpus] 1856—ab
resection (diathermy), [Maitland] 1767—ab
resection (transurethral), urinary obstruction after, [Thompson] 253—ab
toxic hyperplasia, [Barnes] 743—ab
trichomonas infection in male, 1681
PROSTATECTOMY, rechlorination after, 869
PROSTATITIS, Gonorrheal: See Gonorrhea
PROSTIGMINE (Physostigmine): See Myasthenia gravis
PROSTITUTES, preventing syphilis in, 393
PROTAMINE Insulinate: See Diabetes Mellitus
PROTARGOL, Granules Protargol Compound, 1809
PROTEIN: See also Mushroom
effect on action of choline on fat metabolism by liver, 1201—E
in Blood: See Blood
Milk: See Milk
reaction (nonspecific) after transfusion, [Filatov] 1771—ab
Therapy: See also Leukopenia; Mycosis fungoides
therapy, nonspecific, Council investigation, 1172
PROTEOSE in Urine: See Urine
Urine (Oriel P Substance): See Anaphylaxis and Allergy, treatment
PROUST, Professor, successor, 1746
PRURITUS ani, alcohol subcutaneously for, [Haskell & Smith] ★1248
ani, skin disorders underlying, [Hunt] 2201—ab
bath, 559
hiemalis, 559
of jaundice, gangrene after using ergotamine tartrate, [Yater & Cahill] ★1625
of scrotum, roentgen therapy permissible if testis protected, 148
of vulva, estrogenic substance percutaneously, [Zondek] 423—ab
of vulva, skin disorders underlying, [Hunt] 2201—ab
therapy at Cook County, [Fantus] ★2144
PSEUDOLEUKEMIA, [Krumbhaar] ★289
PSITTACOSIS, Drs. Geiger and Meyer ill with, 47
in Vienna, 936
PSORIASIS lymphocytoma simulating, 2020
treatment, adrenal cortex extract, [Grüneberg] 2115—ab
treatment, cevitamic acid, [Lutz] 423—ab
with bullae, [Levin] 158—ab
PSYCHIATRIC Hospitals: See Hospitals
PSYCHIATRISTS, Congress of, France, 935
meet, Germany, 57
U. S. Civil Service positions open for, 1212
PSYCHIATRY: See also Hospitals, psychiatric
education in, conference on, 474; 2014
introducing in medical licensure, [Ebaugh] 1571—ab
methods and aims in, 1328
New England Society of, awards for research, 544, 1740
Parole Clinic: See Hospitals, psychiatric
PSYCHIC and somatic disorders, correlation, [Fetterman] ★26
Frigidity: See Frigidity
PSYCHOANALYSIS, Freud's 80th birthday, 1663—E
Institute, Chicago, 1320; 1664—E
PSYCHOGENIC factor in asthma, 1011—E
PSYCHOLOGY, summer school in, Vienna, 2015
PSYCHONEUROSIS, diagnosis and treatment, [Bennett] 1523—ab
functional, in airplane pilots, [Armstrong] ★1347
PSYCHOSIS, adolescent, 60; 295—E
Depressive: See Mental Depression
preventing loss of weight in, [Finkelman] 156—ab
sequel of carbon monoxide poisoning, [Shillito & others] ★669
symptomatic, in pernicious anemia, [Preu] 572—ab
treatment, narcosustained, with heart lesions, [Magnus] 1602—ab
PTYALISM: See Saliva
PUBERTY: See Adolescence
PUBLIC HEALTH: See Health
PUBLIC SPEAKERS, available, Kansas, 1667
bureau, Arkansas, 543
class in public speaking, Kansas, 1503
PUBLICITY and press, St. Louis Medical Society, 1015
medical, Medical Society of State of New York resolution on, 389
medical press bureau, Sedgwick County Medical Society, Kansas, 1575
PUERPERAL INFECTION after bath or coitus before labor, [Koller] 963—ab
from surgical viewpoint, [Bonney] 1954—ab
prevention, 80
remote results, 59
treatment, transfusion, [Erbslöh] 1238—ab
vaccination in pregnancy, [Bernstine] 1037—ab
PUERPERIUM, eclampsia, [King] 577—ab
PUERTO RICO Medical Association, 305
PULMONARY TUBERCULOSIS: See Tuberculosis, Pulmonary
PULSE, venous, [Merkelbach] 580—ab; [Teufl] 2267—ab
PUNCTURE: See Lungs; Pericardium; Sternum
Ventricular: See Brain
PUPILS (children): See Children, school
PURKINJE, J. E., a Bohemian (not Hungarian), [Suk] 1331—C
PURPURA: See also Dermatitis, purpuric
haemorrhagica, thrombocytopenia from dinitrophenol, [Imerman & Imerman] ★1085
haemorrhagica, thrombocytopenia from food allergy, [Squier] 412—ab
haemorrhagica (thrombocytopenic) after sedormid and phenobarbital, [Boas] 1952—ab
haemorrhagica (thrombocytopenic), induced hypercalcemia, [Lowenburg & Ginsburg] ★1779
haemorrhagica (thrombocytopenic), splenectomy for, [Smith] 1691—ab
haemorrhagica (thrombocytopenic), venom reaction and treatment, [Peck & others] ★1783
haemorrhagica (thrombopenic), experimental, [Tocantins] 1039—ab
haemorrhagica, with intracranial hemorrhage, [Garvey] 880—ab
PUS: See Bacterids; Pyodermia
PYELITIS and cystic ureteritis, [Hinman] 1128—ab
Bacillus coli, alkali therapy, [Osman] 2200—ab
treatment, 116
PYELOGRAPHY, kidney rupture after, [Baretz] ★980
PYELONEPHRITIS, chronic, in children, [Caulk] 577—ab
mucoid form of Bacterium pyocyaneum in, [Dahr] 257—ab
PYEMIA, septic, produced by Bacillus funduliformis, [Lemierre] 426—ab; 1748
PYLORUS stenosis in identical twins, 1568—E
PYODERMIA and irritant dermatitis, 1223
PYOPNEUMOTHORAX complicating acute lung suppuration, [Wood] 156—ab
PYORRHEA, periodontoclasia and gingivitis, [Healy] 2105—ab

Q

QUACKERY: See also Nostrums
charlatanism in old and new world, 1930
clever people and quacks, 2042—ab
Federation of State Medical Boards resolution on broadcasting, 1574
QUARANTINE of flood stricken town, Pa., 1102
mussel poisoning and, California, 2163
QUARTERLY CUMULATIVE INDEX MEDICUS: See American Medical Association
QUESTIONNAIRE: See Rural medical care; Syphilis in pregnancy
QUICK as a Wink, fatal inhalation, [Gonzales] ★286
QUIET Zone: See Clinics
QUINIDINE, anesthesia for thyrocardiac patients, [Flaxman] 144—C (reply) [Lahey Clinic] 144—C
QUININE, action (paradoxical), [Budelmann] 1431—ab
Calcium Treatment: See Pneumonia
dermatitis medicamentosa, [Settle] ★1801
fatal hemoglobinuria with uremia from, [Terplan & Javert] ★529
in induction of labor, persistence of effect, 1681
sulfate, will it cause abortion? 2026
Test: See Hyperthyroidism
Treatment: See Eye diseases; Pneumonia
QUINOLINE Sulfonic Acid: See Amebiasis

R

R. O. T. C.: See Army, U. S.
RABBIT Epithelioma: See Epithelioma
meat, tularemia from, [Amoss & Sprunt] ★1078
RABIES, nurses exposed to, no need for prophylactic treatment, 148
stray dogs and, 2173
Vaccine (Killed Virus) Semple (U. S. S. P. Co.), 617
RABUFFETTI, L., honored, 1510
RACES: See also Indians; Negroes
determination, 148
diets in relation to, 139
problem of, Huxley's address, 2247
white, degenerating in South Africa? 1406
RADIATION: See also Roentgen Rays; Ultraviolet Rays
therapy, 392
RADICULITIS: See Spinal Cord
RADIO, A. M. A. program, 1185; (Kansas City Session) 1498; 1569; 1666
A. M. A. resolution on single short wave frequency for emergency calls, 1823; 1906
advertising, A. M. A. resolution on, 1819
advertising of nostrums, WEMP to refuse, 1401
advertising quackery, Federation of State Medical Boards resolution on, 1574
interference by short wave diathermy—"the shadow," 1094—E
RADIODERMATITIS: See Roentgenotherapy
RADIOEAR De Luxe Hearing Aid, 1805
RADIOLOGISTS, list of, ★618; (certification) 630—E
RADIOLOGY, A. M. A. resolution on division into professional and technical services, 1822; 1904
A. M. A. resolution on group hospitalization plans including, 2007
American Board of, certification by, to replace A. M. A. listing, 630—E
British Institute of, arranges ninth annual congress, 392
Departments: See Hospitals
in medical curriculum, Royal Society of Medicine report, 2248
service in U. S., report, ★618
RADIOPAQUE Pills: See Drugs
RADIOTHERAPY: See Hyperthyroidism
RADIOTHERMY: See Diathermy
RADIUM, American Radium Society, 1323
automatically conveyed by pneumatic pressure through tube protects operator, 1745
sensitiveness and resistance to, 628—E
teletherapy, depth dose in, [Wilson] 1427—ab
Treatment: See Menopause hemorrhage; Rectum cancer; Tonsils, cancer; Uterus, cancer; Uterus, hemorrhage; Uterus, tumors
workers, blood picture in, [Kaplan] 1424—ab
workers, leukocytes variations in, [Goodfellow] 578—ab
workers, protection from gamma rays by building materials, [Kaye] 2109—ab
RADIUS fracture (Colles), treatment, [Masland] 234—C; [Wood] 939—C
RAGWEED (contact) dermatitis, unsuccessful oil desensitization, [Brunsting & Williams] ★1533
pollen extract, Prausnitz-Küstner reaction, [Caulfeild] 334—ab
RAILROAD: See also Train sickness
angina pectoris in locomotive engineer, 2094
RAISINS, brands accepted, 123
RASH: See Exanthem; Pruritus; Urticaria; etc.
RASPBERRIES, Cellu, 123; 215
RAT-BITE FEVER, from field mouse, [Reitzel & others] ★1090
therapeutic, in neurosyphilis, [Rothström] 1434—ab
RATS, crusade against, Amsterdam, 396
on human diet, long term experiment, [Orr] 1132—ab
Tumors: See Tumors
wild, typhus virus in, N.Y., [Nigg] 334—ab
RAWLEIGH'S nostrums, 1837—BI
RAYNAUD'S DISEASE, effect of heat regulation on, [Pearse] 569—ab
possible, 1029
treatment, operations on sympathetic, [Adson] ★361
venoplastic disorders and, 239
RAYS: See Diathermy; Infra-Red Rays; Roentgen Rays; Ultraviolet Rays
RAZ-MAH, 143—BI
READ'S Formula: See Metabolism, basal
RECKLINGHAUSEN'S DISEASE: See Osteitis
RECTOSIGMOID: See Sigmoid
RECTUM: See also Anus
cancer, and surgical diathermy (electrical coagulation), [Strauss] ★285
cancer, lowering operative mortality by intraperitoneal immunization, [Herrmann] 881—ab
cancer, preoperative radium treatment, [Bowing] 654—ab
cancer, prostate cancer simulating, [Kickham] 1853—ab
cancer, surgery in, 2020
stricture, 1838
stricture in lymphogranuloma inguinale, [David & Loring] ★1875
RECTUM—Continued
surgery, eliminating pain after, [Kilbourne] 1606—ab
surgery, oil soluble anesthetics in, [Morgan] 255—ab
Treatment by: See Pelvis
typhoid transmission by, 1224; (correction) 1401
RED CROSS, British, second unit for Abyssinia, 717
in Belgian Congo, 397
International Committee, conference on laws of warfare, 475
RED MONK Tonic, 558—BI
RED SHIELD Brand Pineapple, 1565
REDUSOLS, Dilex, 1587—BI
REFLEX, finger-thumb (basal joint) absent in epileptic attack, [Stiefler] 750—ab
gag, nervous exaggeration, 1940
involvement in trichiniasis, [Merritt & Rosenbaum] ★1646
irritation from mandibular joint factor in glossodynia, [Costen] 251—ab
self-righting, how cars go out of control, 386—E
REFRIGERATION: See Ice, artificial
REGALSU, 143—BI
REGISTRATION: See Harrison Narcotic Act; Licensure
REGISTRY: See Physical Therapy technicians
REGO NO. 333 A, industrial hazards, 1590
RE-JU-VA, 1837—BI
RELIEF: See Emergency Relief
RESEARCH: See also Animal Experimentation; Asthma; Clinical research; Discoveries
centers, Germany, 1020
Fellowships: See Fellowships
Grants for: See American Medical Association; National Research Council
Institute: See Bunge
Laboratories: See Laboratory
Patents: See Patents
progress and experimental method, 608—ab
RESERVE Corps: See Army, U. S.
RESIDENCIES, Hospitals Approved for: See Hospitals, approved
in specialties, 860—E
RESIDENTS, hospital function in training, [Curran] ★753
RESIN, phenolic, sensitizing agent in rhus poisoning, 1841
RESLA, 233—BI
RESORCINOL Reaction (Vernes): See Tuberculosis
RESORPTION: See Vitamin C
RESPIRATION: See also Dyspnea
Artificial: See also Respirator
artificial, by Schafer method plus drawing up elbows, [Héderer] 341—ab
artificial, in nicotine poisoning, [Franke & Thomas] ★507
artificial, kept alive 4 years by, 1402
artificial, methods; cardiac massage to supplement, [Bruns] 884—ab
function tests (Rosenthal, Flach, Monaldi, Gallois) in pregnancy, [Marzetti] 501—ab
vasoconstriction after deep inspiration, [Bolton] 1609—ab
RESPIRATOR, Emerson Diaphragm, 1563
RESPIRATORY TRACT: See also Bronchus; Lungs; Pleura
cancer, roentgen therapy (Coutard), [Harris] 75—ab
defenses, [Thomson] 1234—ab
Disease: See Bronchitis; Bronchopneumonia; Colds; Pneumoconiosis; Pneumonia; Tuberculosis, Pulmonary; etc.
infection, air conditioning relation to, [Hosner] 496—ab
infection in poliomyelitis, [Flexner] 1041—ab
REST: See also Lungs
Home, Della Mostert, operator sentenced, 304
RESUSCITATION: See Asphyxia; Respiration, artificial; Respirator
RETENE, chlorinated, toxicity, 484
RETICULOCYTES increase after injecting "anemic" serum, [Hjort] 1864—ab
RETICULO-ENDOTHELIAL SYSTEM, behavior in provoked hyperlipemia, 2020
roentgen study by injecting thorotrast, [Robins] 74—ab
RETICULOPLASMOCYTOMAS, iliosacral, [Sabadini] 2266—ab
RETICULOSES, [Krumbhaar] ★289
RETINA detachment, frequency after extracting cataract, 1411
detachment in hypertensive toxemia of pregnancy, [Hallum] ★1649
detachment, prognosis; treatment, 1031
detachment, treatment; Gonin's procedure, 718
hemorrhage, relation to leptomeningeal hemorrhages, [Karbacher] 1429—ab
RETROGRADE Urography: See Urography
RHEUMATIC FEVER, Cardiac Complications: See Heart, conduction; Heart disease
eosinophils behavior in, [Friedman] 957—ab
in children, acetylsalicylic acid and magnesium oxide in, [Kaiser] 958—ab
in children, tonsils influence on, [Kaiser] 1764—ab
pleurisy, [Starr] 74—ab
rheumatoid arthritis relation to, [Dawson] 1764—ab
Streptococcus hemolyticus fibrinolysis in, [Stuart-Harris] 1133—ab
RHEUMATIC FEVER—Continued
treatment, salicylates, [Murray-Lyon] 1767—ab
treatment, salicylates, acidosis coma after, 55
vitamin C deficiency and, [Rinehart] 157—ab
RHEUMATISM: See also Arthritis; Endocarditis, rheumatic
Acute Articular: See Rheumatic Fever
acute, institutional treatment, England, 636
articular, subcutaneous nodules in, [Katz] 1432—ab
chronic, fatal poisoning by gold, [Fatzer] 1134—ab
in children, influence of tonsils on, [Kaiser] 1764—ab
in children, sedimentation rate in, [Payne] 746—ab; 925—E; [Massell] 1679—C
International Committee prizes for best works, 1833
International Congress on (fifth), 1325
review (second) by American Committee for the Control of, 1900—E
treatment, histamine injection, [Eastwood] 961—ab
RHINITIS, hyperesthetic, zinc ionization, [Hays] 643—C; [Bernheimer] ★1980
RHINOSCLEROMA: indigenous disease? [Chamberlin] 1600—ab
RHINOSPORIDIOSIS, pathology, [Karunaratne] 1428—ab
RHO, FILIPPO, death, 140
RHUBARB, Cellu Brand, 1987
RHUS; ivy poisoning, pigmentation from iron salts used for, [Traub & Tennen] ★1711
patch tests in, 1938
poison ivy extract prevents dermatitis venenata, [Molitch] 2032—ab
poison ivy sensitivity, tested by acetone extract of leaf, [Field] 1041—ab
poisoning, sensitizing agent in, is phenolic resin, 1841
RIBS cartilage, isolated tuberculosis, [Mühlfelder] 965—ab
fracture (indirect) in pulmonary tuberculosis from coughing, [Richardson] ★1543
RICE powder, lead encephalitis from, 228
RICIN, place of vegetable oils in diet, [McClendon] 64—C
RICKETS, menarche and, [Dworzak] 751—ab
prevention, crystalline vitamin D, [Lewis] 2033—ab
prevention, vitamin D milk, [Haman] 574—ab; 1664—E; [Jeans] ★2066; ★2150
prevention, vitamin D milk, for premature infants, [Davidson] 879—ab
relation of dietary calcium and phosphorus, 2161—E
renal, and dwarfism, [Chown] 1608—ab
RINGER'S SOLUTION, large volume intravenous injection, [Cutter] ★1250
RINGWORM, mycologic infections, 138
of face, neck and arms (Tinea circinata), dihydroxy-anthranol for, [Molitch] ★1563
of scrotum, 1938
RISK, Surgical: See Surgery
RIVAROLA, RODOLFO A., death, 1510
ROBERTS Brand Evaporated Milk, 1474
ROCKEFELLER Foundation: See Foundation
ROCKY MOUNTAIN Spotted Fever: See Spotted Fever
RODENTS: See Lemmings; Rats
ROENTGEN RAYS, analgesic action, [von Mészöly] 751—ab
apparatus in surgical department where ethylene gas is used, policy, 647
apparatus (new), 2016
biologic effects, [Clark] 1766—ab
blood picture in workers with, [Kaplan] 1424—ab
dermatitis after roentgen therapy given 12 years ago, 1841
Diagnosis: See Bronchiectasis; Esophagus, foreign bodies
films, ownership, Supreme Court decision, [Brown] 400—C; 1035—Ml
irradiation (fractional), desensitization of mucosa, [Glauner] 1526—ab
irradiation of scalp, overlapping, [Epstein] 1427—ab
irradiation, reaction elicited by barbiturates and, [Uhlmann] 1236—ab; (reply) [Trostler] 1588—C
irradiation, unilateral castration by, [Momigliano] 748—ab
martyr, William Kraus, 231
Prognosis: See Tuberculosis, Pulmonary
sensitiveness and resistance to, 628—E
ulcers, fresh aloe vera leaf for, [Wright] ★1363
ROENTGENKYMOGRAM: See Heart
ROENTGENOGRAMS: See under Roentgen Rays films; Medicolegal Abstracts at end of letter M
ROENTGENOGRAPHY: See Gallbladder; Lungs; Maxillary Sinus; etc.
ROENTGENOTHERAPY: See also Blood Pressure, high; Brain tumors; Breast cancer; Cancer, treatment; Epithelioma; Erysipelas in infants; Goiter, Exophthalmic; Meningitis; Menstruation disorders; Pruritus; Respiratory Tract cancer; Sweating; Thrombo-Angiitis; Uterus, hemorrhage
radiodermatitis after, given 12 years ago, 1841
ROFFO, A. H., 1510

ROGERS Memorial Sanitarium, 223
ROOM, Dark: See Ophthalmoscope
ROSE CW Short Wave Diatherm, 43
ROSENTHAL Test: See Respiration
ROSS, DONALD, A. M. A. Judicial Council action in Ross-Loos case, 300
ROSS, RONALD, and mosquito day August 2, 1897, 460—ab
ROYAL Society of Medicine committee report on radiology in medical curriculum, 2248
RUBBER Balloons: See Intestines intubation
gloves, dermatitis from, 730; (reply: steep hands in boric acid solution) [Bailly] 1224
RUBELLA, meningo-encephalitis after, [Briggs] 161—ab
placental extract to control, [Gottlieb] 743—ab
RUGAE: See Stomach inflammation
RUHRÄH, JOHN, memorial, 632
RUIZ, FERNANDO, death, 1510
RULER, transparent celluloid electrocardiographic, [Wirtschafter] ★1466
RUPTURE: See Arteries; Bladder; Kidneys; etc.
RURAL area, contacts in tuberculous families in, [Downes] 155—ab
areas, infant mortality higher in, U. S., 1928
districts, physicians for, Rumania, 720
medical care, Bureau of Medical Economics questionnaire, 1914; 1916; 1919
population, communicable diseases in, Illinois, 302
Resettlement Administration, medical service for wards, 1179
RUSH Medical College, 2243
RUSSIA, foreign letter from, 1833
mental disease among foreign born, [Malzberg] 571—ab
Rumanian exchange of students, 481
RYLE, J. A., inaugural lecture at Cambridge, 306

S

S. P. New Discovery Relief Compound: See Snyder's Pills
SACHS Plotz Foundation: See Foundation
SACRO-ILIAC JOINT infection (chronic) [Scott] 1858—ab
pathologic dislocation, [L'Episcopo] 2196—ab
sacrarthrogenetic telalgia, [Pitkin] 741—ab
tumor, reticuloplasmocytomas, [Sabadini] 2266—ab
SAFE PERIOD: See Menstruation
SAFETY: See also National Safety Council
conference, (New Mexico), 1577; (Midwest) 1579
program, traffic, 1743
Public Safety Institute established at Northwestern, 1575
SAFRANIN, for identifying Trichomonas vaginalis, [Miller] ★616
ST. LOUIS Clinics: See Clinics
Medical Society, publicity and the press, 1015
SAJODIN: See Calcium iodobehenate
SALESMAN, fraudulent, D. A. Thomas, 50
SAL-ETHYL Carbonate, Compressed Tablets, with Phenacetin, 2239
SAL-FRUITOL, 143—BI
SALICYLATE: See also Acid, acetylsalicylic; Bismuth; Mercury
acidosis coma after large doses, 55
Treatment: See Rheumatic Fever
SALIGENIN, Iodobismitol with, 382
SALIVA, hypersalivation, 146
SALIVARY DUCTS, blockage, 943
SALMONELLA, infections (systemic) simulating paratyphoid and typhoid, [Wu] 1046—ab
suipestifer infection with surgical complications, [Walker] 1765—ab
SALOON: See Taverns
SALT: See also Sodium chloride
deficient diet and pregnancy, [Lambert] 83—ab
deficiency, pre- and postoperative treatment, [Kirk] 586—ab
free diet, short and painless dilatation as result, [Kárpáti] 84—ab
substitute: glutamic acid, [Mainzer] 2205—ab
SAN DIEGO Exposition, Hall of Medical Science, 1518; (A. M. A. exhibits) 861
SANATORIUM: See also Hospitals, psychiatric; Indian; Tuberculosis
Rogers Memorial, 223
statistics, ★796
SANITATION: See also Hygiene
condition of colonial troops, Italy, 140
lack in beer gardens, [Benning] 1423—ab
lack in France, 637
problems created by foods, 1092—E
SARCOID, Hutchinson-Boeck's disease, [Hunter] 1523—ab
SARCOMA: See also Bone tumors: Breast; Lymphosarcoma
estrogenic hormones in male mice and, 1990—E
pleomorphic, [Davis & others] ★1359
SAUL, CHARLES DUDLEY, group medical service ruled illegal, 1400
SAVOL Cream, 143—BI
SCABIES among well-to-do, [Stokes] ★674
campaign against Germany, 309
in infants, toxicity of sulfur therapy, [Oppenheim] 1137—ab
suit against doctor for indiscretion, 1833
treatment, ammoniated mercury ointment, burns from, 1938
SCALP: See also Alopecia; Hair
irradiation, overlapping in, [Epstein] 1427—ab
oily, treatment, 1755
SCAPULA, fracture, Comelli's sign in, 1750
SCARLET FEVER: See also under Medicolegal Abstracts at end of letter M
clinician and, [Hobson] 2035—ab
closes schools, Illinois, 48
complications, diphtheria, [Zabin] 1588—C; [Levinsohn] 2253—C
complications, hemolytic streptococcus fibrinolysis, [Stuart-Harris] 1133—ab
complications, suppurating meningitis, [Zischinsky] 584—ab
conjunctivitis, [Otto] 584—ab
desquamation in mild form, 2091
epidemic, (Fairbank, Alaska) 132; (New York milk-borne) 1015, 2013; (Wyoming) 1017; (Dawson, Alaska, quarantined) 1212; (Connecticut) 1739
gangrene in, [Blumberger] 1430—ab
Immunity Test, 1809
immunization (active) with less reaction, [Rappaport] ★1076
immunization by innunction, [Ripps] 575—ab
immunization during school epidemic, [Diehl & Hinckley] ★1354
immunization, toxin orally for, 1332
Streptococcus Toxin for Dick Test, 1809
Streptococcus Toxin for Immunization (U. S. S. P.), 1387
toxin, sensitivity to, 1331
treatment, serum results of, 1023
SCARRING: See Tonsillectomy
SCHÄCHTEN: See Animals, slaughter
SCHAFER Method: See Respiration, artificial
SCHAMBERG'S DISEASE, [Michelson] 158—ab
SCHICK TEST: See Diphtheria
SCHILDER'S Disease: See Encephalitis periaxialis
SCHILLER'S Iodine Test: See Uterus cancer
SCHOLARSHIPS: See also Fellowships
for victims of political persecution, England, 1104
Howald, open at Ohio state, 473
SCHOOLS: See also Education; Students; Medicolegal Abstracts at end of letter M
Children: See Children, school
closed for want of children, England, 2016
Desk: See Desk
Epidemic: See Scarlet Fever
for Technicians: See Laboratory; Physical Therapy
intermediate, course reduced in, Japan, 311
medical service, reforms in, England, 636
nurses, Japan, 2173
of Nursing: See Nursing
open air, England, 636
physical education in, England, 866; 2079
tuberculosis (pulmonary) in, 718
SCHOOLS, MEDICAL: See also Education, Medical; Graduates; Students, Medical; University; and under names of specific schools
A. M. A. resolution on instruction in organized medicine, 1188; 1918
accrediting, [Zook] 1096—ab
Association of American Medical Colleges supervision, [Rypins] 1395—ab
candidates examined by licensing boards, ★1476-★1478
Foreign: See Graduates, foreign
National Medical College of Shanghai, 1107
survey, [Rypins] 1395—ab; [Rappleye] 1396—ab
survey, and Federation of State Medical Boards, [Cutter] 1392—ab
two year, [Williamson] 1393—ab; [Upham & others] 1396—ab
undergraduate, allergy teaching in, [Kern] 1409—C
undergraduate, teaching obstetrics in, [Riley] ★1438
SCHRIDDE'S Cancer Hair: See Cancer diagnosis
SCIATICA, treatment, mud baths, injections, diathermy, etc., 235
SCIENCE, Academy of: See Academy
Advisory Board, report, 133
Basic Science Boards: See Medical Practice Acts; Medicolegal Abstracts at end of letter M
discoveries and patents, 1388—E
Kaiser Wilhelm Society for Advancement of Science, Germany, jubilee, 1020
prognosticators, 669—ab
Social: See Social
SCLERODERMA, treatment, ergotamine, 1682
treatment, sympathectomy, [Adson] ★361
SCLEROSIS, amyotrophic lateral, treatment, 1681
multiple, [Simon] 419—ab
multiple, pathogenesis, [Brickner] ★2117
multiple, underwater exercises for, [Scholtz] 1772—ab
SCOLIOSIS: See Spine curvature
SCOPOLAMINE: See Morphine addiction
SCROTUM, allergic edema, 645
dermatitis, persistent, 1938
pruritus, roentgen therapy permissible if testicles protected, 148
SCURVY and potato famines, 1894—ab
congenital, [Jackson] 574—ab
diagnosis, cevitamic acid urinary excretion test, [Wood] 1046—ab
SCURVY—Continued
treatment, cevitamic acid intravenously, [Conrad] 1431—ab
SEA SICKNESS, [Lenggenhager] 2203—ab
SEASON: See also Gonorrhea
variations in acute leukosis, [Engelbreth-Holm] 344—ab
SECRETIN test of pancreatic disorders, [Chiray] 2035—ab
SECTIONS of the A. M. A.: See American Medical Association
SEDATIVES, improved, [Robinson] 419—ab
SEDIMENTATION Test: See Blood
SEDORMID, thrombocytopenic purpura after, [Boas] 1952—ab
SELENIUM, toxic effects, 926—E
SELF-PERFORMED Operations: See Surgery
SEMEN: See Aspermia; Spermatozoa
SEMILUNAR CARTILAGE: See Meniscus
SEMINAL VESICLES, viability of sperm in, 2256
SENEAR-USHER'S DISEASE, [Wirkberg] 664—ab
SENSATION, Burning: See Mouth: Tongue
SENSES: See also Hearing; Taste; Vision
of direction in drivers, 1329
SEPTICEMIA: See also Meningococcemia and Medicolegal Abstracts at end of letter M
due to anaerobic organisms, 2242—E
gonorrheal, with recovery, 56
maternal mortality due to, with antecedent history of abortion, 1938
Pfeiffer bacillus, 2170
staphylococcic, anatoxin, cures, 1508
streptococcic, fatal eyebrow plucking, 54
streptococcic, Vincent serum for, 1673
streptococcic, whole blood injections for, [Hendry] 1610—ab
SEPTICOPYEMIA: See Pyemia
SEPTUM, Nasal: See Nose
SERODIAGNOSIS: See Paratyphoid; Syphilis; Tuberculosis; Typhoid; etc.
SEROLOGY, Utrecht Institute of, 228
SEROTHERAPY: See also Scarlet Fever treatment
limitations, [Wadsworth] 658—ab
sensitization of skin to autoserum, [Bizzozero] 964—ab
SERUM: See also Vaccines
Anemic: See Anemia
Convalescent: See Spider bite
Normal Horse Serum, 617
Plasma: See Blood cholesterol
Proteins: See Blood
Shock; Sickness: See Anaphylaxis and Allergy
Vincent's: See Streptococcus infections
SEVEN BARKS, 64—BI
1776 GEROLIUM Breakfast Cereal, 1565
SEWAGE, Escherichia coli in, Eijkman test, etc., for determining, [Hajna] 252—ab
SEWING mattresses, hazard of tetanus in, 2183
SEX, determination by birthdays of children, [Schöner] 1864—ab
freemartin and intersexuality, 1333
Hormone: See also Corpus Luteum hormone; Estrogenic Substances; Testis hormone; etc.
hormones, male and female, 1748
hormones (male), bitterling test for, [Kleiner & others] ★1643
hypersensitiveness and colon spasticity, 646
Intercourse: See Coitus
Organs: See Genitals
perversion, self-performed operations, [Frost & Guy] ★1708
ratio in children's diseases, [Bonell] 752—ab
rejuvenator, "Prof." Paul C. Bragg again, 1408—BI
Urge: See Libido
SHERRINGTON phenomenon, [Bülbring] 1609—ab
SHOCK, Hemolytic: See Hemoclastic Crisis
Therapy: See Peptic Ulcer
SHORT WAVES: See Diathermy
SHOULDER: See also Clavicle
dislocation, reduction, [Zierold] 338—ab
girdle, pain from arthritis, [Hanflig] ★523
obstetric paralysis, 721
SHWARTZMAN PHENOMENON, inhibition, [Ogata] 657—ab
local, morphology, [Gerber] 1949—ab
SIBLINGS, congenital defects, [Murphy] ★457; [Reid] 1221—C
SICKNESS: See Disease
Insurance: See Insurance, health
SIGHT: See Vision
SIGMOID cancer, diagnostic criteria, [Rosser] ★109
cancer, fecal fistula after resection, 644
cancer of rectosigmoid and, resection for, [MacGuire] 422—ab
passage through dense ring in mesentery, [Cullen] ★895
SILICA in Urine: See Urine
SILICOSIS: See Pneumoconiosis; under Medicolegal Abstracts at end of letter M
SILVER, Ammonia Silver Salt Solution: See Uterus cervix
Granules Protargol Compound, 1809
Nitrate Sticks: See Fistula
Salt Solution Treatment: See Trichomonas; Uterus cervix
Toxicity: See Argyria
Wire Sutures: See Sutures
SIMMONDS' Disease: See Pituitary cachexia
SINAI, NATHAN, 1737—E

SINUS: See also Maxillary Sinus; etc.
pad, Altherm, 921
Thrombosis: See Thrombosis
SINUSES, NASAL, disorders in nurslings, [Schönberg] 1860—ab
catarrhal disorders, exophthalmos in, [Cohen] 1521—ab
sepsis and mental disorders, [Jowett] 1859—ab
SINUSITIS, experimental and clinical, 710—E
treatment, Proetz displacement method, [Gundrum] 161—ab; (with cod liver and halibut oil), 1514
SIPHONOSPORA polymorpha, cause of cancer publicized, 394
666 Salve, 1837—BI
SKELETON: See Bones; Muscles, skeletal
SKIN: See also Dermatology; Epithelium; Tissues
absorption of estrogenic substance, [Zondek] 423—ab
Atrophy: See Dermatitis, atrophic
calcinosis, [Costello] 498—ab
cancer of bridge of nose; roentgenotherapy cures, [Friedman & Engel] ★1879
cancer, predisposition to, vs. blood cholesterol, [Roffo] 166—ab
cancer, rôle of ultraviolet rays, [Roffo] 2111—ab
Desquamation: See Scarlet Fever
Disease: See also Dermatitis; Eczema; Psoriasis; Urticaria; etc.
disease in wood paper industry, 315
disease, viruses in etiology, 1022
disorder underlying pruritus of vulva and anus, [Hunt] 2201—ab
dysplasia (hereditary ectodermal) of anhydrotic type, [Thannhauser] ★908
Elorda Creams, 1678—BI
gangrene (postoperative progressive), [Liedberg] 1616—ab
graft in mastoidectomy, [Shambaugh] 1421—ab
graft; simplified technic, [Sullivan] 234—C
grafting in chronic osteomyelitis, [Armstrong] 2195—ab
grafting small areas, use of elastic adhesive, [Bronaugh] 1856—ab
infection in blondes and red haired people, 1756
infection (staphylococcic) cured with formaldehyde-treated toxoid, 138
infection (staphylococcus), copper sulfate for, [Hannecart] 423—ab
leishmaniasis americana, sodium arsenite for, 1583
microscopic examination for fungi, [Swartz] 1039—ab
nodules, aleukemic myelosis with, [Zimmermann] 2032—ab
oily, treatment, 1755
peel, formula for, 1936
pigmentation after gold treatment, [Cardis] 2203—ab
pigmentation and copper, 629—E; [Alt] 1220—C
pigmentation (pathologic) relation to vitamin C deficiency, [Hoff] 1048—ab
pigmentation (permanent) after using iron salts, [Traub & Tennen] ★1711
pigmentation, postemotional melanotic, [Bonorino Udaondo] 580—ab
pregnancy effect on, [Sharpe & Young] ★682
pyogenic lesions in chronic ulcerative colitis, [Jankelson] 1847—ab
reaction, specific and nonspecific, 46—E
reaction to products of hemolytic streptococcus, [Gibson] 746—ab
reaction with arsenicals; tryparsamide dermatitis, 726; (reply) [Bragman] 1224; [Cormia] 1224
sensitivity in atopic dermatitis, [Sulzberger & Goodman] ★1000
sensitivity, vaccine injections effect on, [Touart] 1042—ab
sensitization to autoserum and autoblood, [Bizzozero] 964—ab
streptococci on, [Colebrook] 340—ab
tags of neck, [Templeton] 1689—ab
temperature after ingesting food, [Booth] 1763—ab
temperature of surface, [Bierman] ★1158
Test: See also Gonorrhea diagnosis; Tuberculin: Undulant Fever
test, 1202—E
test in ragweed (contact) dermatitis, [Brunsting & Williams] ★1533
test (patch) in ivy poisoning, 1938
test (patch) in stomatitis from dental plates, [Rattner] ★2231
tuberculosis transmitted by kissing, [Sulzberger] 314—C
tumor (black), [Roussy] 501—ab
tumor, glomangioma, [Bailey] 250—ab
tumor, neurofibroma, [Sharpe & Young] ★682; [Davis & others] ★1359
SKIPPY Improved Peanut Butter, 215
SKULL: See Cranium
SLAUGHTER: See Animals
SLEEP, disorders, narcolepsy, benzedrine sulfate for, [Ulrich] 1850—ab
disorders, post-traumatic narcolepsy, [Hall & LeRoy] ★431
SLEEP—Continued
disorders, stramonium for postencephalitic drowsiness, [Stott] 500—ab
muscular tension when at rest, 1638—ab
SLIDE Fastener: See Zipper
Test: See Paratyphoid Typhoid diagnosis
SLIM, late toxic results, [Hitch & Schwartz] ★2130
SLOAN, EDWIN P., death, A. M. A. Judicial Council report, 1903; 1922
SMALLPOX incidence (Chicago suburbs) 220; (Iowa) 1398; (U. S.) 1811—E; (France) 2249
vaccination and frequency, 2070—E
vaccination, problems created by the floods, 1092—E
vaccination program of infants and children, 1331
vaccination, rationale after exposure, 401
SMOKE: See Tobacco
Nuisance: See Air
SMOKING: See Tobacco
SMUT: See Corn
SNAKE Venom Reaction: See Purpura haemorrhagica
Venom Treatment: See Hemorrhage; Purpura
SNYDER'S Pills, poisoning, [Motley & McGehey] ★1163
SOAP, nonallergic, 644
SOCIAL aims of mental hygiene, 138
Medicine: See Medicine, socialized; Medicine, state
objective of young physician, [Van Etten] ★772
scientists in medical field, 124—E; [Bergey] 483—C
Security Act, (advisory committees) 51, 1826; (taxation of physicians and hospitals under) 322; 1175; 1179; 1915; 1919; 1996; (health projects) 1212; 1826; 2167
security, "full steam" or caution in, 1737—E
strata, scabies among well-to-do, [Stokes] ★674
SOCIETIES, MEDICAL: See also under names of specific societies; list of Societies at end of letter S
constituent (organization), 1167; (secretaries conference) 1167
county, care of indigent sick, 1095—ME; (plans) 1181
county, leadership in public health education, [Carrington & Kilduffe] ★2098
membership, [Dickinson) 144—C; (jurisdiction) 1168
membership and hospital staffs, A. M. A. resolution on, 1916
plan to disseminate data on bone sarcoma, [Schrock] ★1882
Sociedad de Patologia reunion, 1510
Società italiana di gastro-enterologia, first reunion, 2019
Società Piemontese di chirurgia, 2251
Society for the Protection of Science and Learning, 1672
Society of American Bacteriologists, 132
Society of Illinois Bacteriologists, 1925
state, A. M. A. resolution on removal of hospital from accredited list, 1912; 1921
state and county, Bureau of Legal Medicine and Legislation cooperation, 1179; 1181
SODA, Baking: See Sodium Bicarbonate
SODIUM Arsenite: See Leishmaniasis
Benzoate: See Liver function test; Lungs abscess; Lungs gangrene
bicarbonate-sodium fluoride mixture, poisoning from ingesting, [Geiger] 1339—ab
Bismuth Iodide: See Iodismitol
Cacodylate, Ampoule Solution (Lakeside), 1387
Cacodylate, Cheplin's, 1387
Chloride: See also Salt
chloride, excessive ingestion, effect, [McQuarrie] 1043—ab
chloride, injurious effects, [Keining] 158—ab
chloride, large volume intravenous injections, [Cutter] ★1250
chloride metabolism, effect of adrenal cortex extract on, [Kepler] 414—ab
chloride physiologic solution, washing peritoneal cavity with, 2256
chloride, rechlorination after prostatectomy, 869
chloride reduces colloidal osmotic pressure of blood serum, [Torbert & Cheney] ★683
chloride requirements, causes, [Glatzel] 582—ab
chloride retention, oliguria from, [Lauda] 1239—ab
Chloride Treatment: See Addison's Disease; Arteries, coronary; Toxemia, postoperative
citrate solution isotonic to human blood? [Hirschlaff] 1434—ab
ferrocyanide test of glomerular efficiency, 484
Fluoride: See Fluoride
Hypochlorite: See Breast abscess
Ipral: See Ipral
Morrhuate: See Hemorrhoids; Hydrocele
Sulfate: See Dysentery antiserum
taurocholate, dosage as cholagogue, 487
Thiocyanate: See Blood Pressure, high
SODOKU: See Rat-Bite Fever
SOLDIERS: See also Veterans
antityphoid vaccination Italy, 1933
effect of coffee on efficiency, [Voigt] 1136—ab
SOLITAIRE Brand Grape Juice, 1009
SORBOSE: See Diabetes Mellitus treatment
SORDELLI, A., honored, 1510
SOUNDS, use in urethral stricture, 66
SOUP stock, Loeflund's, 1166
SOUTHEY'S TUBES, improvement, [Leech] ★1895
SPAHLINGER'S Vaccine: See Tuberculosis, bovine
SPANISH-AMERICAN War, beneficiaries for contract surgeons, 1176; 1180; 1913; 1915
SPAS: See Health resorts
SPATULA: See Ulcer, crural
SPAULDING Plan: See Industrial Medicine
SPEAKERS' Bureau: See Public Speaking
SPECIALTIES, official organs detract from A. M. A. special journals, 1168
Boards (certification): See also American Board
boards in, organization, [Bierring] 1097—ab
recognized, Switzerland, 2084
residencies in, 860—E
SPECIFIC GRAVITY: See Urine
SPECTACLES: See Glasses
SPEECH: See also Public Speakers
defects, stammering, blinking and left-handedness, 1681
SPEEDWAY Liniment, 63—BI
SPENCER Supports, 2149
SPERMATIC CORD, division in inguinal hernia, [Burdick] 75—ab
SPERMATOZOA, azoospermia, 2093
infertility and production, 2180
migration in uterine secretions, duration, [Cary] ★2221
viability, factors affecting, 2256
viability in cervical canal, [Seymour] ★1728
SPERTI Process: See Viosterol
SPHINCTER MUSCLES, ileocecal, rôle in intestinal obstruction, [Sperling] 655—ab
vesical, sclerosis, causing micturition disorders in women, [Friedrich] 1049—ab
SPICER, E. H., and Company, 126—E
SPIDER, bite by "knoppie," [Finlayson] 1770—ab
bite poisoning, treatment, 1406
black widow, bite, convalescent serum for, [Gray] 160—ab
SPINA BIFIDA, [Siris] 739—ab
SPINACH, Cellu Brand, 617
green vegetables not necessarily spinach, 601—ab
SPINAL CANAL, wandering bullet in, [Pilcher] 1690—ab
SPINAL CORD compression by ligamentum flavum, [Abbott] ★2129
concussion, 924—E
Degeneration: See also Anemia, Pernicious
degeneration, (subacute combined) peripheral nerves in, [Greenfield] 1131—ab
hematomyelia secondary to hemangioma, [Buckley] 1951—ab
radiculitis, myelitis, after spinal anesthesia, [Brock & others] ★441
surgery, chordotomy, results, [Babtchine] 1235—ab
surgery, chordotomy to relieve pain; voluntary euthanasia, 549
termination, caudal level of, [Needles] 496—ab
SPINAL FLUID: See Cerebrospinal Fluid
SPINE: See also Cauda Equina; Coccyx
caries (progressive) in children; fixation in adults, 1930
curvature (infantile), reduction, [Le Cam] 1692—ab
curvature results of abnormal shortness of allantoic stalk, [Politzer] 967—ab
curvature, rôle in gastroduodenal ulcer, [Pines] 425—ab
curvature, surgical treatment, 637
curvature, treatment, [Whitman] ★112
injuries of cervical vertebrae, brace for handling patients, [Wright] ★1467
injuries (vertebral), diagnostic sign, [Soto-Hall] 338—ab
osteo-arthritis, 941
spondylitis adolescens, [Scott] 1858—ab
spondylolisthesis with low back pain, 1413
surgery, vertebrae exposed in laminectomy, [Bondar] 333—ab
tuberculous spondylitis, healing process in, [Finder] 1953—ab
SPIROCHETOSIS, fusospirochetal lung infections in children, [Taggart] 1690—ab
icterohemorrhagic, meningitic forms, 550; 934
SPLEEN abscess, metastatic, [Walker] 1765—ab
Enlarged: See Splenomegaly
Excision: See Splenectomy
hepatolienal syndromes in undulant fever, [Diehl] 342—ab
resistance factor in poliomyelitis, [Hudson & others] ★2037
SPLENECTOMY: See also Purpura haemorrhagica
blood picture after, in children, [Wollstein] 2261—ab
of normal, effects, [Ask-Upmark] 1138—ab
postsplenectomy erythrocytoid reequilibrations, [Moore] 325—ab
SPLENOMEGALY in children with early hematemesis, [Smith] 160—ab
polycythemia, [Barath] 752—ab
SPLINT: See also Brace; Clavicle; Contracture, Volkmann's
first aid, on ambulances, 628—E; 712
SPONDOLISTHESIS: See Spine

SPONDYLITIS: See Spine
SPONGE, marine, pressure dressing for thyroidectomy wounds, [Bartlett & Bartlett] ★1386
SPORT: See Athletics
SPOTTED FEVER, cultivation of virus, [Bengtson] 163—ab
SPRAINS, [Heald] 2265—ab
heat therapy, [Gill] ★41
SPRUE, etiology and treatment, 385—E
in adult, [Haden] ★261
liver extract effect on intestines in, [Miller] 1849—ab
SPUTUM: See Tuberculosis, Pulmonary
SQUIBB Cod-Halibut Liver Oil, 214
STAB Wound: See Heart: Precordium
STAIN, contrast (safranin) for Trichomonas vaginalis, [Miller] ★616
STAIRS, walking down stairs in heart disease, [Bishop] 401—C
STAM, H. VAN RENKEN, 63—BI
STAMMERING: See Speech defects
STANDBY Brand Evaporated Milk, 1987
STAPHYLOCOCCUS anatoxin, clinical application; fatal reaction, 1326
anatoxin, cure septicemia with, 1508
anatoxin for osteomyelitis of jaw, 1403
anatoxin injections, acute nephritis after, 1403
chronic myositis due to, 310
food poisoning, 2256
genital actinophytosis (Botryomycosis), [Berger] 1949—ab
infected wounds, cod liver oil or glycerin treatment, [Tumanskiy] 260—ab
infections of renal cortex, [Beer] ★1063
infections of skin, copper sulfate for, [Hannecart] 423—ab
infections of skin cured with staphylococcus formaldehyde-treated toxoid, 138
Phagoid-Staphylococcus, 962
STATE BOARD: See also Federation of State Medical Boards
examinations, partial subject averages, [David] ★406
members, aggressive vs. passive attitudes, [Morgan] 1571—ab
regulations to govern licensure of foreign graduates, Oregon, 1505
statistics, ★1475; 1495—E
STATE BOARD REPORTS
Alabama, 407; 2257
Arizona, 240; 1757
Arkansas, 875
California, 564; 2095; 2257
Colorado, 240; 1683
Connecticut, 1334
District of Columbia, 648; 1594
Florida, 487
Illinois, 946; 1941
Indiana, 240; 731
Iowa, 945
Kansas, 648
Kentucky, 1032
Louisiana, 1117
Maine, 731; 2184
Maryland, 407; 1516
Minnesota, 149; 1842
Mississippi, 488
Missouri, 1117; 1682
Nebraska, 875
Nevada, 2095
New Mexico, 946
New York, 1225; 1414
North Carolina, 318; 1031
North Dakota, 2027
Ohio, 1032; 1595
Oklahoma, 68
Pennsylvania, 2184
Puerto Rico, 565
Rhode Island, 2257
South Carolina, 149; 565
South Dakota, 2257
Tennessee, 68; 1117
Texas, 647
Virginia, 731
Washington, 1842
West Virginia, 240
Wisconsin, 149; 2095
Wyoming, 1117; 2184
STATE LABORATORY: See Laboratory
STATE MEDICAL SOCIETIES: See Societies, Medical
STATE UNIVERSITY: See University
STAUCH, FRANCES, sentenced, 2165
STEATORRHEA: See Feces, fat in
STEPHENS Brand Grapefruit Juice, 1735
STERILITY (bacterial): See Sterilization, Surgical; Sutures; Thromboplastic Substances
STERILITY (sexual), diagnosis, roentgen, [Sasaki] 1429—ab
duration of sperm cell migration in uterine secretions, [Cary] ★2221
female, [Rucker] 1131—ab
freemartin and intersexuality, 1333
infertility and production of sperm in dog, 2180
infertility in human, [Rowe] 747—ab
Periodic: See Menstruation, safe period problem, 394
treatment in young couple, 646
tubal factor in, in Chinese women, [King] 2202—ab
STERILIZATION, SEXUAL, authorization, [Woodward] ★33
by high cervical amputation, [Zoefgen] 1957—ab
STERILIZATION, SEXUAL—Continued
of defectives, number, Human Betterment Foundation report, 1827
of persons with hereditary disease, Germany, 1582
tubal, failure in, [Peralta Ramos] 1525—ab
STERILIZATION, SURGICAL, total, [Gudin] 1860—ab
STERNAL NOTCH: See Jugular Notch
STERNUM, branchioma, [Fried] 737—ab
puncture, diagnosis of multiple myeloma by, [Schulten] 2267—ab
puncture, diagnostic value, [Schulten] 2204—ab
STIEDA-KOHLER-PELLEGRINI Disease: See Kohler
STILL'S Disease: See Arthritis
STILLING Plates: See Color Blindness
STIPPLE Cells: See Erythrocytes
STITCHES: See Sutures
STOCKINGS: See Hosiery
STOKES-ADAMS Disease: See Heart block
STOLL'S Diet-Aid, 1111—BI
STOLTE'S "Free Diet": See Diabetes Mellitus, treatment
STOMACH: See also Gastro-Intestinal Tract
Achylia: See Achylia
acidity after gastroduodenal ulcer operations, [Walters] 413—ab
acidity, control by aluminum hydroxide drip, [Woldman] 1338—ab
acidity, hypochlorhydria in asthma, [Gillespie] 80—ab
acidity, significance, [Apperly] 1234—ab
blood formation regulated by, [Vlados] 1957—ab
cancer, anemia in, [Mogensen] 1240—ab
cancer, diagnostic errors, [von Haberer] 502—ab
cancer, early symptoms, [Harris] 1230—ab
cancer, electrocoagulation for, [Strauss] ★285
cancer, extension into duodenum, [Castleman] 1762—ab
cancer metastasis to bone, [Kerr] 249—ab
cancer, modified by tuberculin and B C G vaccine, 1749
cancer, niche as symptom, [Kahlstorf] 166—ab
cancer, palliative irradiation, [Pack] 332—ab
cancer, relation to gastritis, [Derman] 2116—ab
cancer, treatment, [Walters] 1043—ab
cardiospasm (chronic), treatment, [Heyrovsky] 2205—ab
defects, pepsin and hydrochloric acid effect on healing, [Howes] 1045—ab
disorders, value of atropine and belladonna in, [Bastedo] ★85; [Lehnhere] 642—C
diverticulum of cardiac end, [Nathanson] 1767—ab
diverticulum (subcardiac), [Cain] 1611—ab
emptying time, effect of atropine and pilocarpine, [Herrin] 1762—ab
emptying time, ephedrine effect on, [Van Liere & others] ★535
emptying time, relation to acidity of juice, 1750
emptying time; time food remains in stomach, 983—ab
hemorrhages, use of ice bag in? [Dobreff] 1693—ab
inflammation, [Katsnelson] 2116—ab
inflammation, localized hypertrophic (rugae) resembling cancer, [Kantor] 1600—ab
inflammation vs. ulcer and cancer, [Derman] 2116—ab
β methyl ζ-methylamino-β-γ-heptene effect on, [Jackson] ★359
motility, effect of splanchnic resection and of vagotomy, [Barron] 413—ab
motility, hypotonia, anterior pituitary extract for, [Curschmann] 166—ab
mucin, secretion in peptic ulcer, [Anderson] 1603—ab
mucosa, in pernicious anemia, [Jones] 155—ab
Preparations: See also Anemia, Pernicious
preparations, depepsinized juice, [Greenspon] ★266; 295—E; [Hanes & others] ★2058
preparations, standardization; labeling, 1172
Resection: See Stomach surgery
secretion, after ulcer operations, [Paggi] 1611—ab
secretion, effect of alcohol on digestion by gastric juice, [Blotner] ★1970
secretion, intrinsic factor in gastric juice, [Greenspon] ★266; 295—E; [Goldhamer] 1687—ab
secretion of pepsin in various diseases, [Mullins] 77—ab
secretion, time table, [Demole] 341—ab
secretion, use of artificial gastric juice to treat fractures, [Vanovskiy] 1240—ab
surgical wound, zipper closure, [Strauss] ★285
Surgery: See also Peptic Ulcer, surgical treatment
surgery, blood picture after complete removal, [Tateno] 1771—ab
surgery, gastrostomy feeding, [Franseen] ★1373
surgery, toxicity of stagnant content after resection, [Antonucci] 1770—ab
Tonus: See Stomach motility
tubercle bacilli in contents in children, 2017
STOMACH—Continued
tuberculosis and gastric disorders, [Rodriguez Olleros] 341—ab
tuberculosis, relation to pulmonary tuberculosis, 1933
tumors, polyposis, [Van Buskirk] 2195—ab
Ulcer: See Peptic Ulcer
STOMATITIS due to sensitization to dental plates, [Rattner] ★2230
recurrent ulcers of mouth, 1936
STOOLS: See Feces
STOVARSOL: See Syphilis, congenital
STRAIN (over-exertion): See under Medicolegal Abstracts at end of letter M
STRAINS, [Heald] 2265—ab
STRAMONIUM: See Encephalitis, Epidemic
STRAWBERRIES, Cellu, 43
STREAM Pollution: See Water
STREPTOCOCCUS, agglutinations and precipitin reactions in arthritis, [Hartung & others] ★1451
anaerobic, in infectious diarrhea, [Johnston] 497—ab
from gastro-intestinal ulcers and bovine mastitis, [Torrey] 1041—ab
from pasteurized milk, [Wright] 1428—ab
hemolytic, antistreptolysin titers of serum, [Stuart] 2111—ab
hemolytic, bacteremia, [Goldman] 2193—ab
hemolytic, epidemic laryngitis, 1332
hemolytic, fibrinolysis in arthritis and scarlet fever, [Stuart-Harris] 1133—ab
hemolytic, Phagoid-Streptococcus Hemolyticus, 962
hemolytic, precipitin test of, from normal nose and throat, [Hare] 339—ab
hemolytic, skin reactions, [Gigson] 746—ab
in muscle fibers in myasthenia gravis, [Butt] 955—ab
infected wounds, cod liver oil or glycerin for, [Tumanskiy] 260—ab
Infection: See also under Medicolegal Abstracts at end of letter M
infection of renal cortex, [Beer] ★1063
infection, Vincent serum for, 1673
Meningitis: See Meningitis
on human skin, [Colebrook] 340—ab
Scarlatinae: See Scarlet Fever
Septicemia: See Septicemia
STREPTOLYSIN: See Streptococcus, hemolytic
STRIAE: See also Nails
distensae as hypophyseal symptom, [Schilling] 1238—ab
STROPHANTHIN: See Auricular Fibrillation
STRYCHNINE-chloroform mixture, accidents in manufacture and sale, 1745
STUART, F. J., 557—BI
STUDENTS: See also Children, school; Students, Medical
Gibson fund for medical aid for indigent, 1743
health service, university and college, 1182
health, survey, California, 1574
Russian-Rumanian exchange, 481
STUDENTS, MEDICAL: See also Graduates; Internship
choice and admission, [Lyon] 1498—ab
disturbances among, Buenos Aires, Córdoba, 1510
plan for Oxford undergraduates, 134
serve as nurses, U. of Freiburg, 309
training in obstetrics, [Kosmak] ★1435; (correction) 2089—C
SUBARACHNOID Hemorrhage: See Meninges hemorrhage
SUCROSE: See Sugar
SUCTION Treatment: See Acne vulgaris
SUGAR: See also Dextrose
hypertonic sucrose solution, effect on spinal fluid pressure, blood pressure, etc., [Murphy & others] 245—ab
in Blood: See Blood
in Urine: See Urine
SUGGESTION Treatment: See Verruca
SUICIDE, barbital used for, [Chang & Tainter] ★1386
Committee for the Study of, 713; 1324
drugs used for, 1745
of physicians, 1390—E
SULFAMIDO-CHRYSOIDINE: See Erysipelas, treatment
SULFATE, Copper: See Staphylococcus infections
Magnesium: See Chorea, Sydenham's; Magnesium
Sodium: See Dysentery, antiserum
SULFITE, sodium, reaction from hair washes, 1224
SULFOX, 64—BI
SULFUR in Blood: See Blood
Treatment: See also Arthritis
treatment, danger in scabies, [Oppenheim] 1137—ab
SUNLIGHT and health, 2071—E
Brand Oleomargarine, 1987
pigmentation and nutrition, 218—E
sensitivity to, 1756
skin cancer, blood cholesterol and, [Roffo] 166—ab
SUNSHINE Brand Evaporated Milk, 1166
SUNSTROKE: See under Medicolegal Abstracts at end of letter M
SUPERFETATION; twins by different fathers, 730

SUPPORTS: See also Abdomen
Spencer, 2149
SUPPOSITORIES: See Estrogenic Substances
SUPPURATION: See Abscess; Lungs; Meningitis, suppurating; Pericarditis
SUPRARENALS: See Adrenals
SUPRARENIN Powder, Ampules, 617
SURFACE: See Body; Skin
SURGEONS, contract, of Spanish-American War, beneficiaries, 1176; 1180; 1913; 1915
Gloves: See Rubber gloves
International College of, 2162—E
who have operated on themselves, [Frost & Guy] ★1708
SURGERY: See also Amputation; Diathermy, surgical (cross reference); and under names of specific organs and diseases
American Board of, proposed, 1994
Anesthesia used in: See Anesthesia
explosions in operating room, 134
heat in surgical conditions, [Gill] ★40
history, first operation on heart, [Cutler] 725—C
Instruments: See Instruments
International Congress of, Italian surgeons in, 1405
lawful authorization of operations, [Woodward] ★33
"liver deaths" in, [Boyce] 1766—ab
major, in elderly, [Newton] 1954—ab
modern trends in, [Mason] ★1695
National Congress, Italy, 395
Orthopedic: See Orthopedic
Plastic: See Hydronephrosis
Postoperative Complications: See Lungs; Skin, gangrene; Toxemia
postoperative convalescence, intraperitoneal use of amniotic fluid, [Gepfert] 1948—ab
postoperative diet; gastrostomy feeding, [Franseen] ★1374
postoperative dietetic measures in nurslings, [von György] 82—ab
postoperative, hyperthermic syndrome in infants, [Genet] 2268—ab
postoperative nitrogen (nonprotein) retention, 1931
pre- and postoperative treatment of acidosis, salt deficiency, dehydration, [Kirk] 586—ab
preoperative diagnosis; directed biopsy, 718
risk, in cardiac disease, [Hickman] 332—ab
risk in peptic ulcer, weight loss indicates, [Studley] ★458
self-performed operations, [Frost & Guy] ★1708
Società Piemontese di chirurgia, 2251
Société de chirurgie changed to Académie de chirurgie, 718
Sutures: See Sutures
syphilis transmission during operation, danger, 486
Technic: See Needle
Traumatic, Institute of, (correction) 862
use of operating room for perforation in typhoid, 1939
Zipper Closure of Wound: See Stomach
SUTURES, catgut, sterility, [Clock] 338—ab; (Council investigation), 1172; 1807
catgut, tetanus from, 1019
cesarean uterine, pregnancy after sloughing, [Fist] 1331—C
insertion before laceration in childbirth, 2094
needle, [Nelson] ★1005
silver wire, preventing excoriation of perineum, [Grad] 570—ab
SWALLOWING, electrical anesthesia for dysphagia, [Grain] 2112—ab
SWAMP FEVER, 1391—E
SWEATING, anhydrosis, [Thannhauser] ★908
excessive, roentgen therapy, [Pirie] 1602—ab
function, [Brown] ★354; ★355
hyperhidrosis (essential), operations on sympathetic in, [Adson] ★362
unilateral, 148; (reply) [Stieglitz] 487
SWEET'S Bear Brand Salve; Certified Blood Tea, 143—BI
SWIMMING and acute otitis media, 2178
Pool Underwater Therapy: See Crippled; Paralysis, treatment
urticaria probably not related to, 2024
SYDENHAM'S Chorea: See Chorea
SYDENSTRICKER, EDGAR, death, 1102
SYMPATHECTOMY: See also Angina Pectoris; Uterus cancer
cervical, effects, 2182
Horner's syndrome after, 1411
indications, [Adson] ★360
lumbar, effect on growth of paralyzed legs, [Harris] 741—ab
SYMPATHICOTHERAPY, quackery in France, 1930
SYMPATHIN E and I, [Jackson] ★359
SYMPATHOBLASTOMA, intrathoracic, [Frost] 1847—ab
SYMPHYSIS PUBIS, relaxation in pregnancy, [Thoms] ★1364
SYNOVITIS, allergic, from eating walnuts, [Lewin & Taub] ★2144
SYPHILIS: See also Venereal Disease; under names of specific organs and diseases; under Medicolegal Abstracts at end of letter M
bony union as affected by, 485
Cardiovascular: See Cardiovascular Disease
cause of sterility, 394
SYPHILIS—Continued
Cerebrospinal: See Neurosyphilis
clinics, delinquent patients in, Baltimore, [Reinhard & Fales] ★1377
congenital, acetarsone (stovarsol) for, [Davidson] 956—ab
congenital, fontanel closure and dentition in, [Ugarte] 81—ab
congenital, infectiousness, 873
congenital, leontiasis ossea relation to, [Scharff] 1773—ab
congenital, prevention, 637
congenital, roentgen-positive seronegative, [Ingraham] 495—ab
control, as next public health objective, 1390—E
control, U. S. Public Health Service committee report, [Vonderlehr & others] ★115
early, gonorrhea as mask for, [Kemp] 954—ab
economic loss to community from, 643
Diagnosis: See also Syphilis, serodiagnosis
diagnosis of the undiagnosed syphilis, [Bainbridge] 2197—ab
glaucoma (primary) and, [Beckh] 570—ab
headaches due to, 486
in child 2 years old, 316
in pregnancy, [Nelson] ★105; [Exner] ★490
in pregnancy cause of heart block, [Bernstein] ★532
in pregnancy; questionnaire, [Exner] ★488
in pregnancy, treatment, [Cole & others] ★464; [Bernstein] ★532; 872
incidence, decreasing prevalence, [Nelson] ★105
latent, treatment, 1113
nursing infant by mother with, 1515
Optic Atrophy: See Nerves, optic
placenta fibrosis and, [Montgomery] 1229—ab
prevention, bismuth intramuscularly, 393
serodiagnosis, [Basu] 1858—ab
serodiagnosis, Chediak's dry blood method, [Wendelborn] 662—ab
serodiagnosis, in pregnancy in private practice, [Exner] ★490
serodiagnostic test, evaluation, [Senear] 1044—ab
third generation, [Rosenbaum] 575—ab
transmission by blood transfusion, [Mandelbaum & Saperstein] ★1061
transmission by needle prick during operation, 486
Treatment: See also Syphilis, congenital; Syphilis in pregnancy
treatment, 403; 1223; 2254
treatment: alternating arsenicals and bismuth, 1332
treatment, arsphenamine sensitive patient, 1413
treatment, bismuth or mercury with arsphenamine, [Cannon & Robertson] ★2133
treatment, bismuth orally, [Kemp] 1688—ab
treatment complicated by kidney disorders, 729
treatment, gold and arsphenamine in tuberculosis complicating, [Gómez] 581—ab
treatment, hyperpyrexia by hot bath, [Dennie] 657—ab
treatment (inadequate) effect on neurosyphilis, [Kemp] 880—ab
treatment, iodobismitol with Saligenin, 382
treatment, mapharsen, 214; [Foerster] 418—ab; 1332
treatment, neoarsphenamine given intravenously vs. intramuscularly, 646
treatment of early syphilis, [Ormsby] ★1241
treatment, under vs. overtreatment, [Hall] 160—ab
treatment with heart disease, 944
tuberculosis with, [Guild] 739—ab
Wassermann-fast, 147
SYPHILOLOGY, American Board of, 1498
Congress of, Italy, 1750
training of interns in, [Clark & Exner] ★767
SYRINGOMYELIA, surgical treatment, [Frazier] 2103—ab
SYRUP, brands accepted, 214; 782; 923
cerasiae (syrup of cherry), formula, 404
SYSTOLE: See Heart

SOCIETIES

Acad.—Academy
Am.—American
A.—Association
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical
Med.—Medicine
Nat.—National
Phar.—Pharmaceutical
Phys.—Physicians
Rev.—Revision
Ry.—Railway
S.—Surgical
Soc.—Society
Surg.—Surgery
Surgs.—Surgeons

Acad. of Physical Med., 305
Alabama, M. A., of the State of, 1319, 1925
Allegheny County (Pa.) M. Soc., 1505
Am. Acad. of Arts and Sciences, 635
Am. Acad. of Ophthalmology & Oto-Laryngology, 474, 1827
Am. Acad. of Orthopedic Surgs., 474
Am. Acad. of Pediatrics, 1578
Am. A. for the Advancement of Science, 223, 2015
Am. A. of Anatomists, 1212, 1743
Am. A. of the History of Med., 1018
Am. A. of M. Milk Commissions, 1505
Am. A. on Mental Deficiency, 1103, 2078
Am. A. of Obstetricians, Gynecologists & Abdominal Surgs., 1579
Am. A. of Pathologists & Bacteriologists, 1743, 1828
Am. A. for the Study & Control of Rheumatic Diseases, 1324
Am. A. for the Study of Goiter, 1743, 2015
Am. Coll. of Phys., 50, 635, 1103
Am. Committee on Maternal Welfare, 1323
Am. Cong. of Physical Therapy, 547, 715, 1018, 1670
Am. Council on Education, 931
Am. Dietetic A., 305
Am. Gastro-Enterological A., 2078
Am. Gynecological Soc., 2167
Am. Heart A., 1323
Am. Institute of Nutrition, 1018
Am. Laryngological, Rhinological & Otological Soc., 547, 2167
Am. Neisserian M. Soc., 1579
Am. Neurological A., 2167
Am. Orthopedic A., 1670
Am. Orthopsychiatric A., 223
Am. Pharmaceutical A., 1579
Am. Physical Education A., 715
Am. Physiological Soc., 1579
Am. Physiotherapy A., 715
Am. Proctologic Soc., 1323
Am. Psychiatric A., 1928
Am. Psychoanalytic A., 223
Am. Public Health A., 1578
Am. Radium Soc., 1323
Am. Red Cross, 475
Am. Social Hygiene A., 1324
Am. Soc. of Biological Chemists, 1579
Am. Soc. for Clinical Investigation, 2078
Am. Soc. for the Control of Cancer, 1324, 1576
Am. Soc. for Experimental Pathology, 1579
Am. Soc. for Experimental Pharmacology & Therapeutics, 1579
Am. Soc. for the Hard of Hearing, 1018
Am. Soc. of Tropical Med., 132
Am. Speech Correction A., 132
Am. Student Health A., 223
Am. Urological A., 715, 2167
Arizona State M. A., 1099, 1397, 1925
Arkansas M. Soc., 543, 1397, 1824
A. of Am. Phys., 223, 1577, 2015
A. for the Internat. Protection of Humanity, 1828
A. for Protection Against Aerial Warfare, Netherlands, 396
A. for Research in Ophthalmology, 1505
A. for the Study of Allergy, 1324
A. for the Study of Internal Secretions, 1670
Berlin Pediatric Soc., 309
Biological Photographic A., 1579
Brazilian Cong. of Cancer, 311
British Cong. of Obstetricians & Gynecologists, 1210
British M. A., 58, 137, 548
California M. A., 387, 1099, 1666, 2073
California Tuberculosis A., 1501
Canadian M. A., 1929
Catholic Hosp. A. of the United States & Canada, 50, 1018
Central Soc. for Clinical Research, 324, 412
Chicago M. Soc., 130, 220, 471, 472, 632
Chinese M. A., 1107
Clinical Orthopedic Soc., 50
Colorado State M. Soc., 129
Committee for the Study of Suicide, 1324
Conf. of State & Territorial Health Officers, 1323
Cong. of Comparative Pathology, 1106
Cong. of German Gynecologic Soc., Berlin, 394
Cong. of Internal Med., Italy, 639
Cong. of Orthopedics, Italy, 721
Cong. of the Pan-Pacific S. A., 715
Cong. of Psychiatry & Neurology, Belgium, 935
Cong. of Radiology, 392
Connecticut State M. Soc., 2073
District of Columbia, M. Soc. of, 2164
Eugenics Research A., 1324
Federation of Am. Societies for Experimental Biology, 1579
Florida M. A., 1320, 1398, 1575, 2011
French Cong. on Hygiene, 1507
French Cong. of Stomatology, 548
French Gynecologic Cong., 135
Georgia, M. A. of, 1320, 1824, 1925
German Soc. for Tropical Med., 932
History of Science Soc., 474
Illinois State M. Soc., 387, 1739, 2074
Illinois Tuberculosis A., 1398, 1575
Indiana State M. A., 302, 1014, 1926
Institute of Med. of Chicago, 220
Internat. A. of Preventive Pediatrics, 718
Internat. Conf. on Tuberculosis, 2078
Internat. Cong. for Experimental Cytology, 548, 1744
Internat. Cong. on Gastro-Enterology, 1744
Internat. Cong. on Hepatic Deficiency, 548
Internat. Cong. on Hepatic Insufficiency, 1744
Internat. Cong. for Juvenile Protection, 2083
Internat. Cong. on Light, 1325
Internat. Cong. on Malaria, 2078
Internat. Cong. on Mental Hygiene, 475
Internat. Cong. of Microbiology, 1325

Societies—Continued
Internat. Cong. on Occupational Diseases, Belgium, 1675
Internat. Cong. of Pediatrics, 932
Internat. Cong. of Physical Med., 548, 715, 1506, 1745
Internat. Cong. for the Protection of Childhood, Belgium, 397
Internat. Cong. of Psychology, 1744
Internat. Cong. on Rheumatism, 1325
Internat. Cong. of Surg., 1405
Internat. Genetics Cong., 548
Internat. Pacific Health Conf., 139
Internat. Soc. of the History of Med., 1744
Internat. Soc. of Orthopedic Surg., 1744
Internat. Soc. of Surg., 1744
Internat. Sports Physicians' Cong., 1744
Iowa State M. Soc., 1398, 1926
Kansas M. Soc., 712
League of Nations, 306
Louisiana State M. Soc., 1503, 2012
Maine M. A., 1926
Maryland, M. & Chirurgical Faculty of, 1740
Massachusetts M. Soc., 1209, 2012
Massachusetts Soc. for Mental Hygiene, 303
M. Days of Brussels, 932
M. Library A., 1670
M. Women's Nat. A., 2015
Michigan Pathological Soc., 388
Michigan State M. Soc., 130, 221, 634, 1101, 1209, 1503, 1576, 1927
Mid-South Post Graduate M. Assembly, 305, 931
Minnesota Soc. of Internal Med., 49
Minnesota State M. A., 472, 545, 1101, 1503
Mississippi State M. A., 1576, 2012
Missouri State M. A., 1209, 1825
Montana, M. A. of, 2165
Nat. Acad. of Med. of Mexico, 932
Nat. Anti-Tuberculosis Cong., Italy, 1021
Nat. A. for the Prevention of Tuberculosis, 1744
Nat. Committee on Maternal Health, Inc., 2078
Nat. Committee on Mental Hygiene, 132, 474
Nat. Conf. on Visual Education & Film Exhibition, 1743
Nat. Cong. of Parents & Teachers, 716, 1743
Nat. Cong. of Urology, 310
Nat. Health Council, 1018
Nat. M. A., 2078
Nat. Research Council, 1743
Nat. Safety Council, 132, 1018
Nat. Soc. for the Advancement of Gastro-Enterology, 223, 716, 1928
Nat. Soc. for the Prevention of Blindness, 2078
Nat. S. Cong., Italy, 395
Nat. Tuberculosis A., 715, 1018, 1928, 1929, 2078
Nebraska State M. A., 1741
New England Obstetrical & Gynecological Soc., 1928
New England Soc. of Psychiatry, 544
New Hampshire M. Soc., 1668, 2165
New Jersey, M. Soc. of, 1927
New Mexico M. Soc., 1504
New York Acad. of Med., 131
New York League for the Hard of Hearing, 304
New York, M. Soc. of the State of, 389, 1399, 1741
North Carolina, M. Soc. of the State of, 1577, 2013
North Dakota Acad. of Ophthalmology & Otolaryngology, 2166
North Dakota State M. A., 1742, 2076
North Pacific Surgical Association, 474
Northwest Regional Conf., 391, 1018
Ohio State M. A., 1669
Oklahoma State M. A., 389, 1211, 1742, 1928
Oregon Tuberculosis A., 1578
Pacific Northwest Soc. of Pathologists, 474
Pan-American M. A., 931
Pan-Pacific S. Cong., 1828
Pennsylvania, Hosp. A. of, 131
Pennsylvania, M. Soc. of the State of, 1211
Pennsylvania Radiological Soc., 2014
Pennsylvania Tuberculosis Soc., 389
Philadelphia County M. Soc., 1322, 1400
Philippine Islands M. A., 931
Puerto Rico M. A., 305
Radiological Soc. of North America, 50
Rhode Island M. Soc., 1103
St. Louis M. Soc., 1015
Soc. of Am. Bacteriologists, 132
South Carolina M. A., 1322, 1827
South Dakota M. A., 1505, 2077
Southeastern S. Cong., 50, 864, 1324
Southern Psychiatric A., 1324
Southern S. A., 305
State & Provincial Health Authorities of North America, 2015
Tennessee Acad. of Ophthalmology & Otolaryngology, 2077
Tennessee State M. A., 132, 1323, 1827
Texas, State M. A. of, 1669
Tri-State M. A. of the Carolinas & Virginia, 931
Washington State M. A., 1212
Wayne County (Mich.) M. Soc., 1015
Western Ophthalmological Soc., 1103
Western S. A., 305
Wisconsin, State M. Soc. of, 2077
World Cong. of Jewish Phys., 932

T

TABES DORSALIS, fractures and, 67
gastric crisis, [Binet] 962—ab
TACHYCARDIA, paroxysmal, pressing hard on vagus nerves to relieve, 1333
TADPOLE Experiment: See Goiter, Exophthalmic
TAGS, Cutaneous: See Skin
TAKAHASHI, GONZABURO, Manchurian typhoid martyr, 2174
TAKATA ARA TEST: See Liver function
TAKATA Reaction: See Liver insufficiency
TALMA'S operation, [Henningsen] 1612—ab
TANNIN Treatment: See Burns; Tuberculosis
TAPE, Adhesive: See Adhesive
Test: See Tuberculin
TASTE, disorders in influenza, [Schwanke] 967—ab
TATOOING: See Eyes
TAUBMANN, Dr., killed by patient's brother, 1404
TAUROCHOLATE: See Sodium taurocholate
TAUSSIG'S Procedure: See Uterus cervix
TAVERNS, lack of sanitation in beer gardens, [Benning] 1423—ab
TAX, duty increased on surgical instruments from Germany, 2163—E
income, 127; 1940
income, and birth rate, England, 2247
on ground of prescription writing, Bucharest, 480
of physicians and hospitals under the Social Security Act, 322
on professions, 393
TEA, Wilkins Tea, Orange Pekoe, 782
TEACHER, tuberculous, school children infected by, 1674
TECHNICIANS: See Laboratory; Physical Therapy
TEETH: See also under Medicolegal Abstracts at end of letter M
abscess (apical) 65; (reply) [Winslow] 1515
dentin desensitization (Hartman's solution), [Hartman] 2108—ab
eruption, in congenital syphilis, [Ugarte] 81—ab
mottled enamel, 67; (endemic fluorosis) 630—E
stomatitis from sensitization to dental plates, [Rattner] ★2230
TELANGIECTASIS, treatment, fresh aloe leaf, [Wright] ★1363
TELETHERAPY: See Radium
TEMPERATURE, proper, for offices, 145
TEMPERATURE, BODY: See also Skin
effect on viability of sperm, 2256
subfebrile, [Lauda] 2205—ab
water intake and reduced cooling powers, [Gregory] 2034—ab
TEMPORAL ARTERIES: See Arteritis; Periarteritis nodosa
TEMPORAL BONE: See also Petrositis
involvement in head injuries, [Skoog] 1616—ab
TEMPORAL LOBE: See Brain tumors
TEMPOROMANDIBULAR JOINT, congenital bony, [Burket] ★1719
TENDONS, fingers, damaged, repair, [Mayer] 953—ab
connection of muscle fiber and, 2183
TENDON'S SPACE, implantation of gold sphere in, 2181
TERATOMA, neural components, [Willis] 2111—ab
of testis, [Craver & Stewart] ★1802
TERMINOLOGY: See also "Words and Phrases" under Medicolegal Abstracts at end of letter M
corpus luteum hormone, Council report, 1808
definition and etiology, 468—E
ileocolitis ulcerosa chronica, [Rosenblate & others] ★1797
"medical profession" and "medical opinion," [Woodward] ★1897
TESCHNER, P. A., assistant director Bureau of Health and Public Instruction, 219; 1184
TESTIS extract, Androstine-Ciba, 2150
Hormone: See also Prostate hypertrophy
hormone secreted in urine, female bitterling test, [Kleiner & others] ★1643
inflammation after mumps, [Ohlmacher] ★2053
tumor, teratoma, [Craver & Stewart] ★1802
undescended, gonadotropic substance for, [Koplin] ★374; [Spence] 962—ab; [Allen & Stokes] ★780; [Dorff] 1111—C; 1507; [Werner & others] ★1541
undescended, neoplasms in, [Christoffersen] 1419—ab
undescended (perineal) [Campbell] ★2232
TETANUS antitoxin, auditory nerve involvement after, [Cutter] ★1006
antitoxin, sensitivity, 1515
from catgut sutures, 1019
hazard in sewing mattresses, 2183
immunity (acquired natural), 1673
immunization, no incompatibility in pertussis and, 148
Toxoid, Alum Precipitated, N.N.R., 1735; 2239
transmitted by capricorn beetle bite, [Schmorell] 169—ab
treatment, excising portal of entry in, 135
TETANY in adult, [Haden] ★261
in asthmatic after epinephrine, [Ellsworth & Sherman] ★284
port of entry of, [Bustos] 749—ab
vitamin D and parathyroid hyperplasia, [Wilder & Howell] ★427; [Quick] 871—C
TEXAS Centennial Exposition (A. M. A. exhibit) 861; (incubator babies) 2077
TEXTILE Industry: See Industrial
THAMES Valley Unsweetened Evaporated Milk, 467
THEATRICAL Grease Paint: See Cosmetics
THEELIN: See Estrogenic Substances
THEELOL: See Estrogenic Substances
THEOBROMINE: See Arteries, coronary; Thrombo-Angiitis obliterans
THEOPHYLLINE: See Arteries, coronary; Thrombo-Angiitis obliterans
THERAPEUTICS: See also Physical Therapy; Serotherapy; Vaccine Therapy; etc.
device, Copeland Bill, 1175; 1179; [Woodward] ★1896; 1902—E
lawful authorization, [Woodward] ★33
therapy of Cook County Hospital, [Fantus] (coughs) ★375; (nontuberculous lung abscess by Bettman) ★1728; [Lilienthal] 2253—C; (pruritus by Cornbleet) ★2144
THERMO Theraputor, Briggs', 122
THERMOMETERS, inaccurate, convicted for sale of, 1325
THIOCYANATE in Blood: See Blood
THIOSULFATE, Sodium: See Empyema, tuberculous
Treatment: See Blood Pressure, high
THOMAS, HUGH OWEN, tragedy, 476
THOMSEN'S Disease: See Paramyotonia congenita
THORACIC DUCT lymph pressure in conretio cordis, [Bialock] 958—ab
THORACOPLASTY: See also Tuberculosis, Pulmonary
unsatisfactory, surgical revision, [Kinsella] 1522—ab
THORAX: See also Hemopneumothorax; Pneumothorax; Pyopneumothorax
chest deformities induced in asthmatic, 134
chest examinations of school children, New York City, 633
drainage of cavity, tubing for, [Lilienthal] 2253—C
movements in unilateral pneumothorax, [Bock] 1136—ab
tumor, neurinoma, [Dyggve] 1774—ab
tumor sympathoblastoma, [Frost] 1847—ab
THORIUM, Colloidal Dioxide (Thorotrast): See also Brain roentgen study; Brain, ventriculography; Reticulo-Endothelial System
colloidal dioxide (thorotrast) effects on liver, [Rigler] 336—ab
dioxide injection, organs years after, [Naegeli] 2114—ab
THOROTRAST: See Thorium
THROAT: See also Neck; Pharynx; Tonsils
classification of hemolytic streptococci from, [Hare] 339—ab
cytoplasmic inclusion bodies in, [Broadhurst] 1950—ab
Hospitals: See Hospitals
irrigation by gargles, [Kaunitz] 1679—C; [Walker] 2253—C
surgery, control of bleeding in, [Brown] 2265—ab
THROMBO-ANGIITIS OBLITERANS: See also Arteriosclerosis obliterans
Buerger's disease a special form, [Lindenbaum] 1136—ab
in aged, 646
Raynaud's disease and, 239
tobacco and, [Trasoff] 1689—ab
treatment, operations on sympathetic, [Adson] ★362
treatment, Pavaex, [Conway] ★1153; [Wilson & Roome] ★1885
treatment, roentgen, [Pfahler] 654—ab
treatment, theobromine or theophylline, 1413
THROMBOCYTOPENIA: See Blood platelets; Purpura haemorrhagica
THROMBOCYTOSIS: See Blood platelets
THROMBOPHLEBITIS, treatment, 1755
treatment, venous ligation, [Napalkow] 1955—ab
THROMBOPLASTIC SUBSTANCES, sterility, Council report, 1172
THROMBOSIS: See also Embolism; Thrombophlebitis
cerebral, pain in limbs after, 1756
coronary, acute fatal, [Levy & Bruenn] ★1080
coronary, contributory causes, [Phipps] ★761
coronary, differentiating from pulmonary embolism, [van Bogaert] 661—ab
coronary, filament nonfilament leukocyte count after, [Goodrich] 326—ab
coronary, glycosuria and hyperglycemia in, [Raab & Rabinowitz] ★1705
coronary, life expectancy in, [Willius] ★1890
coronary, relation to heart block, [Salcedo-Salgar] 569—ab
coronary, sedimentation reaction in, [Shookhoff] 1421—ab; [Christensen] 2036—ab
etiology, 310
National Surgical Congress of Italy discusses, 396
popliteal aneurysm, [Wells & others] ★1264
preventive treatment, pedaling "bed bicycle," [Dalsgaard] 1138—ab
sinus, [Wolf] 576—ab

THROMBOSIS—Continued
sinus (superior longitudinal), spontaneous, [Biemond] 169—ab
treatment, papaverine, [de Takáts] ★1003
treatment, Pavaex; ligating arteries, [Conway] ★1144
tumor-thrombus filling vena cava and heart cavities, [Woodruff & Levine] ★1544
THROT-EASE, 143—BI
THUMB: See Fingers
-Finger Reflex: See Reflex
THYMUS, focus of nucleoprotein accumulation, 869
syndrome in new-born, [Graham] 1130—ab
THYROID: See also Goiter; Goiter, Exophthalmic
antithyroid protective substances (Blum's Katechin), [Schumacher] 168—ab
cancer, pathogenesis; radiotherapy, [Levin] 2198—ab
deficiency, investigation, 1839
desiccated, and low basal metabolic rate, [Berkman] ★2042
diseases in children, [Cockayne] 660—ab
disorders, iodine requirement of man, 541—E
effect of tobacco smoke, 2181
Excision: See Thyroidectomy
extract, exophthalmos after, [Brain] 1691—ab
extract, thyrotoxicosis from, 2023
Hormone (Thyrotropic): See Pituitary, anterior
Hyperthyroidism: See Hyperthyroidism
hypophyseothyrogenic adiposity and emaciation, [Wahlberg] ★1968
Hypothyroidism: See Hypothyroidism
insufficiency in cachexia hypophyseopriva (Simmonds' disease), [Rose] 1852—ab
Preparations: See also Thyroid, desiccated; Thyroid extract; Thyroxine
preparations, use and abuse, [Short & Johnson] ★1776
refractory state induced to thyrotropic hormone, [Bruner & Starr] 247—ab
THYROIDECTOMY for angina pectoris, [Bisgard] ★1639
subtotal, auricular fibrillation recurs after, [Boas] ★2238
wounds, marine sponge as pressure dressing, [Bartlett & Bartlett] ★1386
THYROTOXICOSIS: See Goiter, Exophthalmic
THYROTROPIC Principle: See Pituitary
THYROXINE, relationship to adrenal cortical hormone and nitrogen metabolism, 542—E
vitamin C counteracts, [Schäfer] 1861—ab
TIBIA, abscess of lower end, 1940
TIC, Diaphragmatic: See Diaphragm flutter
Douloureux: See Neuralgia, trigeminal
TIGER-SNAKE Venom: See Hemorrhage treatment
TIGRI, ATTO, commemoration, 721
TIN foil, hazard from chocolate, 1590; (also tobacco) [Williams] 2178—C
TINEA: See Ringworm
TINNITUS AURIUM, 729
vertigo and, 645
TISSUES: See also Epithelium; Liver; Placenta; Skin; Tumors
Bacterium tularense viability in, [Foshay & Mayer] ★2141
connective, reaction to lipids, [Tompkins] 953—ab
effects of iodine followed by zinc on, 1594
heating by short wave diathermy, [Coulter & Carter] ★2063
oxidation in B_1 avitaminosis and inanition, [Rydin] 170—ab
saturation with nitrogen and caisson disease, [Shilling] 163—ab
soft, injuries, primary excision, [Schüle] 502—ab
TOBACCO: See also Nicotine
cigaret smoking (excessive) effect on maternal health, [Campbell] 1761—ab
condemned, England, 2079
"cure" nostrum, Health Anti-Tobacco, 2088—BI
effect on blood cholesterol content, [Strauss] 1237—ab
heart sensitivity to, 943
lead poisoning in cigar makers, [Jordans] 968—ab
metal foil on, hazard, [Williams] 2178—C
smoke, action on small intestine, [Simici] 2113—ab
smoke, constituents, 2181
smoking, acidity, 945
smoking effect on stimulus for pressure, [Wenusch] 1773—ab
thrombo-angiitis obliterans and coronary artery disease, [Trasoff] 1689—ab
α-TOCOPHEROL, chemistry of vitamin E, 1496—E
TOES, hammer, surgical treatment, [Regele] 1956—ab
Pigeon: See Metatarsus varus
TOMATOES, Cellu Brand, 707
juice, brands accepted, 1166; 1387
TONGUE, burning, 403; (reply) [Greenbaum] 940—C; [Rattner] ★2230
glossodynia, [Costen] 251—ab; [Gilpin] ★1722
painful, 2256
TONSILLECTOMY, bacteria in blood stream after, [Fischer] 1432—ab
capsule (so-called), 1841
TONSILLECTOMY—Continued
in hemophiliac, 66; (reply) [Kugelmass] 404
premedication and inhalation anesthesia, [Gwathmey] 1230—ab
scarring after, 1841
treatment of syphilis, 729
TONSILS, cancer, radium, x-rays and surgery for, [von Kisfaludy] 2115—ab
effect on rheumatic infection in children, [Kaiser] 1764—ab
Infected, Gargling: See Gargles
TOOTH: See Teeth
TOPMOST Brand Apple Sauce, 1009
TOPOGRAPHY: See Cranium
TORTICOLLIS, sternomastoid muscle injury in new-born, [Galloway] ★507
spasmodic, operative treatment, 480
TORULA histolytica, meningitis due to, [Sawers] 255—ab
TORULOSIS, [Mitchell] ★450
TOWT-NOLAN Laboratory, Lactobacillus Acidophilus Milk, 1165
TOXEMIA of Pregnancy: See Pregnancy
postoperative, sodium chloride solutions for, 2080
TOXICODENDROL, sensitizing agent in rhus poisoning, 1841
TOXIN: See Pneumococcus; Scarlet Fever
Cobra: See Cancer, pain in
TOXIN-ANTITOXIN: See Diphtheria
Coley's: See Cancer treatment
TOXOID: See Diphtheria; Staphylococcus; Tetanus
Test of Moloney: See Diphtheria
TRACHEA: See Laryngotracheitis
TRACHEOTOMY, larynx tuberculosis requiring, [Myerson] 1040—ab
TRACHOMA in Palestine, 2080
treatment, zinc ionization, [Edison] 1421—ab
TRAFFIC Accidents: See Automobiles
TRAIN: See also Railroad
sickness, [Lenggenhager] 2203—ab
TRANSFUSIONS: See Blood Transfusion
TRANSPLANTATION: See Graft (cross reference); Muscles
TRANSUDATES, differentiating exudates from, [Fucci] 2113—ab
TRAUMA: See also Accidents; Aneurysm; Bone atrophy; Elbow; Osteochondritis; Myositis; Paralysis, deltoid; Paralysis, facial; Sleep disorders; Spine; Tissue; and under Medicolegal Abstracts at end of letter M
diagnosis of pain in, 1676
Industrial: See Industrial; Workmen's Compensation Acts
metabolism disorders caused by, [Cuthbertson] 1608—ab
TREATMENT: See Therapeutics
TRENDELENBURG Operation: See Embolism, pulmonary
TRIBOULET Reaction: See Intestines tuberculosis
TRIBROM-ETHANOL: See Anesthesia
TRICHINOSIS, cancer and, [Schmidt-Lange] 1433—ab
in Louisiana, [Hinman] 744—ab
nervous system involvement in, [Merritt & Rosenbaum] ★1646
TRICHLOROACETIC Acid Treatment: See Moles; Verruca
TRICHLOROETHYLENE: See *tri*Chloroethylene
TRICHOMONAS infection in male, 1681
treatment, phenylmercuric nitrate, [Biskind] 340—ab
vaginalis cause of leukorrhea, 1412
vaginalis, contrast stain (safranin) for, [Miller] ★616
vaginalis vaginitis iodochlorhydroxyquinoline (vioform) for, [Huffman] 157—ab
vaginalis vaginitis, treatment; husband as carrier? 1589
vulvovaginitis, silver salt solutions in ammonia for, [Werbatus] 581—ab
TRICHOPHYTIN, hypersensitivity to, 943
preparations, desensitization by, 1591
reaction, diagnostic value, [Knierer] 1048—ab
TRICHOTILLOMANIA, [Karrenberg] 582—ab
TRIGEMINAL Neuralgia: See Neuralgia
TRIMETHYLENE (cyclopropane): See Anesthesia
TRINITROPHENOL, instill into nostrils, [Armstrong] 1424—ab
TRIPOLI as source of silicosis, [McCord] ★913
TROOPS: See Army, Italian
TROPICAL Air Line: See Aviation
medicine, new research committee, 1580
Ulcers: See Ulcer
TRU-LI-PURE Brand Pasteurized Homogenized Milk, 1473
TRUNK'S Prescription, 1111—BI
TRUPAK Premium Baking Chocolate, 1387
TRYPANOSOMIASIS, American, Sociedad de Patologia reunion discussed, 1510
TRYPARSAMIDE, chemical relation to carbarsone and acetarsone, [Epstein] ★771
dermatitis, 726; (reply) [Bragman] 1224; [Cormia] 1224
no records of allergic sensitivity, 564
patent and trademark, Council report, 781
TRYPSIN digestion by, effect of alcohol, [Blotner] ★1970
TUBERCLE BACILLUS, bacillemia, 308; (Loewenstein method) [Siegel] 331—ab
Bovine: See Meningitis, tuberculous; Tuberculosis, bovine; Tuberculosis; Pulmonary
chemical constitution, 1021
"dissociation," [Besta] 503—ab
filter-passing particles, measurement, [Fraenkel] 748—ab
in gastric contents in children, 2017
Killed, Inhalation: See Tuberculosis, immunization
life duration in sputum exposed to sun, [Zink] 1136—ab
of mammals, pathogenicity, for chickens, [Grünberg] 585—ab
TUBERCULIN, desensitization with, [Selter] 585—ab
positive children observed for 5 years, [Weintraub] 1124—ab
reaction, allergy, and immunity, 540—E
reaction (focal), cell picture, [Baar] 663—ab
reaction in cancer, [Holmgren] 1434—ab
reaction, (positive) in nontuberculous pulmonary disease, [Nissler] 417—ab
reaction, variations in French army, 1931
stomach cancer modified by, 1749
test (Hamburger percutaneous) of school children, 1674
test (Lovett percutaneous; Wolff tape), 2178
TUBERCULOMA of central nervous system, [Jaffé] 1600—ab
TUBERCULOSIS: See also Tuberculosis, Pulmonary; under names of specific organs and diseases
A. M. A. Session on, 1295; (minutes), 2008
anthropometric study of children, [Pryor] 1600—ab
Antituberculosis Society, Italy, 1021; 1933
Austral Pacific Zone, 139
avian, in cattle, 2080
blood in, [Miller] 1952—ab
Bovine: See also Meningitis, tuberculous
bovine bacillus in lesions in man, [Gróh] 1049—ab; [Brown] 1422—ab
bovine bacillus in, occurrence, [Gróh] 1049—ab
bovine, (Connecticut free from), 1666; (40 states free from) 2078
bovine, in U. S. Government dairy herd, 548
bovine, Spahlinger's vaccine for preventing, 224
Cancer and: See Cancer, tuberculosis and
complicating syphilis, [Gómez] 581—ab; [Guild] 739—ab
complications, gastric disorders, [Rodriguez Olleros] 341—ab
contacts in families in rural area, [Downes] 155—ab
control, group roentgen examinations, 639
diagnosis, Meinicke reaction, [Berdel] 169—ab; [Lämmli] 750—ab; 1831
diagnosis, Vernes resorcinol reaction, 550
economic and social problems in, [Cutler] ★1368
etiology of erythema nodosum, [Aguirre] 1429—ab
etiology of phlyctenular keratitis, 2248
etiology of rheumatoid arthritis, [Copeman] 1133—ab
etiology, rôle of influenza, 2251
Fistula: See Fistula, tuberculous
hospitals, ★792
hospitals, A. M. A. considers Senate Bill 4516, 1821; 1920
Illinois Tuberculosis Association, 1398
immunity, [Selter] 585—ab
immunization, [Corper] 1951—ab
immunization BCG, infant infected by cured (?) mother, 2169
immunization BCG, infant infected by parent, 2169
immunization, BCG, tuberculous (bovine type) meningitis in infant after, 2170
immunization by inhaling killed tubercle bacilli, [Westenrijk] 501—ab
immunization of guinea-pigs, [Branch] 331—ab
immunization with dead tubercle bacilli, [Berg] 749—ab
in childhood, [Fine] 73—ab
in children, active diphtheria immunization, [Starcke] 1861—ab
in children, anthropometric study, [Pryor] 1600—ab
in children, erythrocyte resistance in, [Andreucci] 963—ab
in children from tuberculous teacher, 1674
in families, 125—E
in nurses, 637
in pregnancy, 1754
insurance in, 1021
International Conference on, 2078
liquefaction, rôle of bacillus and of "hetero-allergy" in, [Pagel] 2201—ab
mortality and dispensaries, France, 477
National Tuberculosis Association, 715; 1018
National Tuberculosis Council, Cuba, 2078
nostrum, Resia, 233—BI
open incurable, segregation of patients, [Hanke] 1049—ab
prevention, 397
preventorium in desert, 471
sanatorium, Association of Italian Clergy, 230
Sanatorium Conference, New York City, 546
sanatorium, Cragmor, reorganized, 927

TUBERCULOSIS—Continued
sanatorium for American Indians, Minnesota, 130
sanatorium, Northwoods, (correction) 1401
sanatorium, opening for physician, Wisconsin, 2167
Serodiagnosis: See Tuberculosis diagnosis
sex urge in patients, [Barglowski] 1861—ab
swindler with, 1212
therapeutic abortion for, 2024; 2168
Transmission: See also Chancre, tuberculous
transmission diaplacental, [Lucksch] 1525—ab
treatment, acid, [Von Kapff] 166—ab
treatment, in general hospitals, [Hiebert] 1409—C
treatment, tannin, [Loumos] 739—ab
treatment, vitamin D, [Zeyland] 2112—ab
Vaccination: See Tuberculosis, immunization
vaccine (B C G) injection prevents serum shock, [Fraenkel] 1042—ab
TUBERCULOSIS, PULMONARY: See also Empyema, tuberculous
abdominal compression in, supports for, [Gordon] 417—ab
amenorrhea in, [Gál] 586—ab
artificial pneumothorax (bilateral) in, necropsy proved clinical cure, 1933
artificial pneumothorax (bilateral) in, pleuritis during, 1933
artificial pneumothorax in, increasing importance, [Cutler] ★1366
artificial pneumothorax in, roentgen observations, [Pershina] 1774—ab
artificial pneumothorax (unilateral) in, movements of thorax in, [Bock] 1136—ab
blood in, monocyte-lymphocyte ratio, [Bresci] 2266—ab
blood picture in, [Houghton] 80—ab
bovine type of bacillus causing, [Goeters] 966—ab
complications, asymptomatic undulant fever; treatment, 1030
complications, diabetes, [McKean] 324—ab
diagnosis, histamine test, [Videla] 341—ab
diagnosis of cavities, [Wachtel] 258—ab
diagnosis, sputum cultures for, 1105
diaphragm elevation in, 1406
epituberculosis, [Dufourt] 165—ab; [Benda] 1235—ab; [de Bruin] 1434—ab
heart enlargement (reversible) in, [Rosenblatt] 2177—C
hemoptysis fatal in, 1673
hemoptysis, intratracheal water injections for, [Pennetti] 1342—ab
hemorrhage (perifocal and traumatic) [Pagel] 1427—ab
hemorrhagic pleurisy, [Korol] 1124—ab
in children, chest examinations, New York City, 633
in Puerto Rico, [Rodríguez Pastor] 2034—ab
in the school, 718
infiltrates (secondary) in children, [Lichtenhahn] 1134—ab
lung stasis, [Maestrini] 1955—ab
pathogenesis, [Oppenheimer] 251—ab
peculiar form, [Dyggve] 1434—ab
phrenic paralysis induced in, in cavitation, [Slavin] 331—ab
phrenicectomies or phrenic alcoholizations, [Jullien] 1341—ab
phrenicothlasty in, [O'Shaughnessy] 2201—ab
pleural adhesions in, [Drash] 1607—ab
postprimary, endogenous reinfection and exogenous superinfection, 1021
prognosis, x-ray, [Trudeau] ★592
rib fracture from coughing, [Richardson] ★1543
sputum examination, 1112
sputum exposed to sun, effect on longevity of tubercle bacillus, [Zink] 1136—ab
sputum, lipoid myelins in, [Risi] 169—ab
sputum, yeastlike fungi in, [Ying] 1524—ab
stomach tuberculosis relation to, 1933
thoracoplasty (anterolateral) in, [Thevarthundil] 1341—ab
transmission from articles made at home and sold to public, Italy, 1022
treatment, climate, 1406
treatment, collapse, effect on menstrual physiology, [Jameson] 1037—ab
treatment, gold, 311; (fatzer) [Fatzer] 1134—ab
treatment of bilateral cavernous type, [Coryllos] 2262—ab
treatment, parenteral oxygen, [Frola] 1430—ab
treatment, pulmonary rest by posture, [Pierson] 738—ab
tuberculomas of central nervous system relation to, [Jaffé] 1600—ab
TUBES: See Southey's; Thorax, drainage
TULAREMIA—disease of lemmings, [Sylvest] 2206—ab
from ingesting rabbit meat, [Amoss & Sprunt] ★1078
treatment, specific antiserum, [Flinn] 251—ab
viability of Bacterium tularense in human tissues, [Foshay & Mayer] ★2141
TUMORS: See also under organs and specific types of tumors
black, of skin, [Roussy] 501—ab
Brown-Pearce, [Bauer] 581—ab
TUMORS—Continued
clinic (annual) (Hines), 1100; (Joliet) 1502
formation, rôle of estrogenic substance in, 1093—E
like amyloidosis, congo red test, [Rosenblum & Kirshbaum] ★988
Malignant: See also Cancer; Chorionepithelioma; Melanoma; Sarcoma; etc.
malignant, features, Lister Memorial Lecture, 2079
multiple tumor syndrome, [Davis & others] ★1359
nuclei measurement and chromosome count in, [Schairer] 425—ab
rat, effect of stoppage of blood supply, [Chambers] 1428—ab
superior pulmonary sulcus (Pancoast), [Frost] 1847—ab
-thrombus, filling inferior vena cava and right heart cavities, [Woodruff & Levine] ★1544
tissues, cytologic study, [Fidler] 737—ab
TUNG OIL, poisoning from paint, 238
TURKEY: See Food poisoning
TWIN Ulcers: See Peptic Ulcer
TWINS by different fathers—superfecundation, 730
crisis in research on, 719
freemartin and intersexuality, 1333
identical, pathology, 1568—E
TYPHOID, acute yellow atrophy of liver caused by, [Beumer] 258—ab
carriers, supervision, New York, 1826; 2166
diagnosis, blood clot culture an adjunct to Widal test, [Laybourn] 880—ab
diagnosis, rapid slide test, [Welch] 1762—ab
diarrhea prevents it from developing, [Robertson] 1232—ab
epidemic (at county home, N. Y.), 1102; (at Mansfield, O.), 1400
in large cities of U. S., ★1983
Manchurian, Dr. Takahashi martyr of, for which he discovered the cause, 2174
meningitis, 1221
mortality, U. S., ★1983
-Paratyphoid Prophylactic, 122
perforation in, use of operating room for, 1939
Salmonella infections simulating, [Wu] 1046—ab
transmission by rectum, 1224; (correction) 1401
vaccination, 1224
vaccination of soldiers, Italy, 1933
vaccination plan of infants and children, 1331
vaccination problems created by floods, 1092—E
Vaccine: See also Arthritis, treatment
vaccine effect on blood coagulation, [Simon] 419—ab
TYPHUS martyrs, Dr. Monteiro and Dr. de Andrade, 310
virus disease, 138
virus in wild rats in New York City, [Nigg] 334—ab

U

UDDERS inflammation and milking machines, 1213
inflammation, streptococcus from, relation to gastro-intestinal ulcer, [Torrey] 1041—ab
ULCERS: See also Colitis, ulcerative; Peptic Ulcer; etc.; under Medicolegal Abstracts at end of letter M
contact, of larynx, [Woodruff] ★1562
crural, rubbing in Wilkinson's ointment with wooden spatula for, [Alke] 1431—ab
Roentgen: See Roentgen Rays
treatment, cod liver oil, [Iost] 586—ab
trophic, sympathectomy in, [Adson] ★364
Tropical: See also Leishmaniasis
tropical, diet in relation to, 139
Twin (Kissing): See Peptic Ulcer
Varicose: See Varicose Veins
ULTRASHORT WAVES: See Diathermy
ULTRAVIOLET RAYS, cancer development and, [Roffo] 2111—ab
Eveready Professional Carbon Arc, 1899
irradiated amebas, [Black] 254—ab
Irradiated Substances: See Milk; Viosterol
Lamp, Fischerquartz, 1806
Therapy: See Empyema, therapy
UMBILICUS Fistula: See Fistula
UMBRELLA, curtained, as portable dark room, [Olsho] ★115
UNCLE WILLIAM Brand Tomato Juice, 1166
UNDERNUTRITION: See Nutrition
UNDERTAKERS: See Embalming
UNDERWATER Exercises: See Crippled; Paralysis
UNDULANT FEVER, asymptomatic, treatment, 1030
diagnosis, serologic, 1746
hepatolienal syndromes in, [Diehl] 342—ab
in France, 2249
prevention; treatment, 1754
skin testing material, where obtained, 2026
treatment, immunotransfusion, opsonocytophagic index to select donors, [Creswell & Wallace] ★1384
vaccination with living vaccines, danger, 2248
UNEMPLOYED, sickness among, Massachusetts, 472
physical condition, 46—E
UNITED HOSPITAL Fund: See Hospitals
UNITED MEDICAL SERVICE, Inc., v. People, 632
UNITED STATES Army: See Army
Civil Service positions for psychiatrists, 1212
Constitution Sesquicentennial Commission, 1823; 1920
Department of Labor, industrial medicine in, 1176; 1180
government dairy herd, tuberculosis in, 548
Veterans' Administration: See Veterans
UNIVERSAL Bovie Unit, 1008
UNIVERSITY: See also Harvard; McGill; Ohio State; Oxford; etc.
accrediting, [Zook] 1096—ab
health service, 1182
of Budapest, tercentenary, 553
of Chicago, Rush Medical College, 2243
of Heidelberg, 1402
of Illinois, 220; 1320
of Kansas, 1208; 1304
of Michigan, 1503
of Paris, 550
of Pennsylvania, 50
of Rochester, 304
responsibility in medical training, [Gilmore] 1206—ab
scientific discoveries and patents, 1388—E
state, and professional education, [Willard] 1098—ab
UPHAM, JOHN HOWELL JANEWAY, A. M. A. President-Elect, 1811—E; 1813—E; (address) 1923
URACHUS, persistent, in adult, [Wilmoth] ★526
UREA clearance, ferrocyanide excretion relation to, [Gordon] 415—ab
clearance test, formula, 484 (correction) 635
diphtheria bacilli differentiation and, [Püschel] 1772—ab
elimination in diabetes insipidus, [Hanssen] 884—ab
in Blood: See Blood
in Urine: See Urine
Treatment: See Blood urea
UREMIA, fatal hemoglobinuria with, from quinine, [Terplan & Javert] ★529
from transfusion, [DeGowin] 416—ab
posthemorrhagic, [Meyler] 968—ab
URETERITIS, cystic, and pyelitis, [Hinman] 1128—ab
URETEROLITHOTOMY: See Ureter calculus
URETERS anastomosis (transuretero-ureteral), [Higgins] 253—ab
anomalies, double ureter, [Hawthorne] ★189
anomalies in children, surgical treatment, [Campbell] ★194; ★195
anomalies, rôle in causation of surgical conditions, [Gutierrez] ★183
calculus, vaginal ureterolithotomy, [Shaw] 1853—ab
changes in pregnancy, [Hundley] 249—ab; [Traut] 659—ab
injuries during hysterectomy, 1831
intestinal implantation, [Wright] ★1804
obstruction, kidney function in, [Wilcox] 330—ab
obstruction (noncalculous ureteropelvic), [Harris] 418—ab
prolapse in herna, [Røvig] 84—ab
URETHRA, absence (very rare), [Stevens] ★89
Electrotomy: See Prostate hypertrophy
obstruction (congenital) in female, [Stevens] ★89
prostatic, congenital valve formation in, [Aalkjaer] 1958—ab
stenosis, micturition disturbances in women, [Friedrich] 1049—ab
stricture, electro-urethrotomy for, [Riba] ★1971
stricture, use of galvanism and sounds in, 66
trichomonas infection in male, 1681
URETHRITIS: See under Medicolegal Abstract at end of letter M
Gonorrheal: See Gonorrhea
URETHROGRAPHY in female, [Stevens] 1128—ab
URINARY TRACT: See also Bladder; Genito-Urinary Tract; Kidney; Ureters; Urethra
anomalies in children, surgical treatment, [Campbell] ★193
calculi, [Higgins] 253—ab
calculi and anaerobic bacillus, [Runeberg] 1434—ab
calculi and parathyroids, [Barney] 2109—ab
calculi and vitamin A, 1172
calculi, in bone diseases, 469—E
changes in pregnancy, [Hundley] 249—ab
epithelium, heterotopic osteogenesis from, [Lucinesco] 2035—ab
infection and chronic cervicitis, [Herrold] 659—ab
tumors in upper, [Freudenthal] 344—ab
URINATION disturbances, rare forms in women, [Friedrich] 1049—ab
frequency in women, diagnostic significance, [Wear] 1767—ab
frequency with enlarged prostate, 873
incontinence and meningocele, 67
incontinence, operations for, [Martius] 1049—ab
obstruction after transurethral prostatic resection, [Thompson] 253—ab
retention, intestinal atony and hemorrhage from gastric ulcer, [Melchior] 1433—ab

URINE, acidity and alkalinity tests, 1590
Albumin: See Albuminuria
Albumin Precipitin Test (Marks): See Peptic Ulcer
Blood in: See Hematuria
Cevitamic Acid in: See Urine, vitamin C
chemistry, artificial fever effect on, [Simon] 1042—ab
citric acid in metabolism, 1737—E
creatinine in diabetes insipidus, [Hanssen] 884—ab
creatinuria in adult males, [Taylor] 1123—ab
creatinuria in cardiac decompensation, [Kindler] 1612—ab
creatinuria of infancy and childhood, [Marples] 879—ab
cylindruria in digestive disorders, [Rohmer] 256—ab
Dextrose: See Urine sugar
diastasuria in pneumonia, [Pavel] 967—ab
extracts, pressor substances in, in arterial hypertension, [Capps] 159—ab
fructosuria, essential, [Marble & Smith] ★24
galactosuria as liver function test in pneumonia, [Canali] 1135—ab
Hemoglobin in: See Hemoglobinuria
Histidine in: See Pregnancy, diagnosis
Incontinence: See Urination
indican, demonstration, [Szajna] 83—ab
of Pregnant Women: See Pregnancy, diagnosis; Pregnancy extract
oliguria from sodium chloride retention, [Lauda] 1239—ab
oxalic acid elimination in nephrolithiasis, [Herkel] 1772—ab
pinkish or red color and food, 2092
porphyrin in, and lead poisoning, [Franke & Litzner] 585—ab; [Roth] 585—ab
Precipitin Test for Albumin: See Peptic Ulcer
Proteose: See also Anaphylaxis and Allergy, treatment
proteose, multiple myelomas with amyloidosis, [Rosenblum & Kirshbaum] ★988
silica excretion in nonsilicotic subjects, [Goldwater] 1603—ab
specific gravity (low), 2182
sugar, Benedict's solution (formula given) for, 942
Sugar in: See also Diabetes Mellitus; Glycosuria
sugar, potassium ferricyanide test for, [Guglliucci] 1860—ab
Therapeutic Use: See Anaphylaxis and Allergy treatment; Pregnancy urine extract
urates in, cause pink discoloration of stools, 1938
urobilinuria after water tolerance test in hepatic diseases, [Adlercreutz] 1694—ab
vitamin C, cevitamic acid excretion test in scurvy, [Wood] 1046—ab
vitamin C (cevitamic acid), relation to diet, [Chakraborty] 1859—ab
vitamin C excretion after giving orange juice, cevitamic acid, [Hawley] 1604—ab
vitamin C in, determination, technic, [Ammon] 966—ab
UROBILINOGEN in Feces: See Feces
UROGRAPHY, extraneous shadows complicating; radiopaque pills, [Hartung & Wachowski] ★598
intravenous and retrograde; comparative study, [Cumming & Chittenden] ★602
UROLOGY, American Board of, 1401
Congress of (first), Brazil, 1583
female, observations on, [Stevens] 1128—ab
National Congress of (fourteenth), Italy, 310
URTICARIA, 2024
in child, cause and treatment, 1593
of unknown etiology, 1027
USEFUL DRUGS: See American Medical Association
UTENSILS: See Cooking; Glassware
UTERUS Adnexa: See also Fallopian Tubes
adnexa, hemangioma, 1333
cancer, alcohol intraspinally and sympathectomy for pain, [Greenhill] 1229—ab
cancer, Botelho's seroreaction, 1583
cancer (cervical), diagnosis by Schiller's iodine test and colposcopy, [Hinselmann] 343—ab; [Bucher] 962—ab
cancer (cervical), postoperative irradiation, [Friedl] 2115—ab
cancer (cervical) radium plus exteriorization, [Daels] 1239—ab
cancer (cervical), relation to labor, [Tompkins] 249—ab
cancer (cervical), Wertheim's operation for, [Bonney] 570—ab
cancer of retained cervix or subtotal vs. total hysterectomy, [Meigs] 1230—ab
cancer, radiologic treatment, international statistics, 1235—ab
cervical amputation, sexual sterilization by, [Zoefgen] 1957—ab
cervical canal, spermatozoa viability in, [Seymour] ★1728
cervical metritis, electrocoagulation for, [Cotte] 423—ab
cervicitis, and urinary infection of, [Herrold] 659—ab
cervix, endocervicitis and erosions, ammonia silver salt solutions injected into, [Kritschewsky] 1773—ab
UTERUS—Continued
cervix, endocervicitis (chronic), 2181
cervix, endocervicitis, phenylmercuric nitrate for, [Biskind] 340—ab
cervix, interstitial radiation (Taussig's) [Duncan] 2102—ab
contractions, amniotic fluid effect on, [Fom' ...] 965—ab
contractions, progestin and progynon-B fect on, [Falls & others] ★271
curettage advisable for recurring miscarriage, 317
excision, preservation of menstruation after, 1328
excision, ureter injuries during, 1831
Hemorrhage: See also Menopause hemorrhage
hemorrhage after normal delivery, [Küstner] 503—ab
hemorrhage, congo red treatment, [Nikolajew] 84—ab
hemorrhage, functional, [Wilson] 1426—ab
hemorrhage, physical therapy (x-ray or radium), 135
hydatidiform mole with bleeding; Aschheim-Zondek or Friedman test, 1680
intra-uterine pressure during labor pains, 1514
measurements of nonpregnant and pregnant, 1841
Mucosa: See Endometrium
prolapse, Gellhorn and Menge pessaries, 67
prolapse, index of excursion in, [Jürgens] 883—ab
roentgen diagnosis for sterility, [Sasaki] 1429—ab
roentgen study in abdominal pregnancy, [Greenhill] ★606
secretions, sperm cell migration in, [Cary] ★2221
tumor, fibroid, effects of radium on genital tissue, 1590
tumor, fibroid, in pregnancy, 1594
tumor, fibroid, treatment, 1939
tumor, fibroid, x-rays for, does tumor entirely disappear? 1333

V

VACCINATION: See also Immunization; Poliomyelitis; Puerperal Infection; Smallpox; Typhoid; Undulant Fever; Yellow Fever; etc.
encephalitis after, etiology, [Heerup] 1864—ab
in France in 1934, 867
revaccination, specific and nonspecific skin reactions, 46—E
VACCINES: See also Bacillus coli; Poliomyelitis; Rabies; Typhoid
autogenous, in asthma, [Napier] 2200—ab
dmelcos, 404
injections, effects on skin sensitivity, [Touart] 1042—ab
ketene for detoxification, [Tamura] 959—ab
Oil Suspended: See Fibrositis, treatment
Spahlinger's: See Tuberculosis, bovine
Therapy: See also Arthritis, treatment; Bacillus, coli; Leprosy; etc.
therapy, limitations, [Wadsworth] 658—ab
VAGINA Douche: See Douche
mucosa, cyclic changes, [Zondek & Friedmann] ★1051
spermatozoa viability in, 2256
Ureterolithotomy: See Ureter calculi
VAGINITIS after radium treatment of uterine fibroid, 1590
Gonorrheal: See Gonorrhea
treatment, phenylmercuric nitrate, [Biskind] 340—ab
Trichomonas: See Trichomonas
VARICELLA: See Chickenpox
VARICOSE VEINS, lymphedema occurring with, [Biegeleisen] 2032—ab
of forearm, 318
treatment, injection, controlled by x-ray, [Herlyn] 81—ab
treatment, injection, mortality statistics and, 1114
treatment with ulcers, 1030
VARIOLA: See Smallpox
VAS DEFERENS cancer, [Thompson] 576—ab
VASOCONSTRICTION: See Vasomotor Mechanism
VASOMOTOR MECHANISM, vasoconstriction after deep inspiration, [Bolton] 1609—ab
vasoconstriction, measurement, [Brown] ★353; ★354; ★355
VEGEMUCENE, ethical "patent medicines," 1172
VEGETABLES: See also Carrots; Potatoes; Tomatoes; etc.
Cellu Brand Combination, 1387
green, not necessarily spinach, 601—ab
homogenization for infants, value, 2025
Lecithin: See Lecithin
oils, place in diet, [McClendon] 64—C
raw, oxidizing ferments and digestion, [Matvieeff] 1134—ab
strained, brands accepted, 123; 1165
VEGETRATE, 1111—BI
VEINS: See also Blood Vessels; Phlebitis; Thrombophlebitis
ligation in septic diseases of extremities, [Napalkow] 1955—ab
Portal: See Portal Vein
VEINS—Continued
Pressure: See Blood Pressure, venous
Pulse: See Pulse
roentgen study with Diodrast, in obstructive lesions, [Barker & Camp] 246—ab
valves relation to body surfaces, [Edwards] 1688—ab
Varicose: See Varicose Veins
velocity of blood circulation from cubital and dorsal veins, [Bertola] 1692—ab
VENA CAVA, inferior, tumor-thrombus filling, [Woodruff & Levine] ★1544
VENEREAL DISEASE: See also Gonorrhea; Lymphogranuloma inguinale; Syphilis
clinic, delinquent patients in, Baltimore, [Reinhard & Fales] ★1377
clinic, new, Maryland, 1825
control, U. S. Public Health Service committee report, [Vonderlehr & others] ★115
control (WPA funds for, New York City), 1102; (Budapest) 1749; (Oregon) 2014
legislation, violations, Germany, 1215
problems created by the floods, 1092—E
VENOGRAPHY: See Veins, roentgen study
VENOM, Bee: See Arthritis, treatment
Cobra: See Cancer, pain; Cobra
Reaction: See Purpura haemorrhagica
Snake: See Snake venom (cross reference)
Treatment: See Hemorrhage; Purpura haemorrhagica
VENTILATION: See Air conditioning; Kaiseraire Filter Ventilator
VENTRICULAR FIBRILLATION, epinephrine disposes to, [Nathanson] 314—C
rarely demonstrated in man, [Raisbeck] 440—ab; [Reid] 1513—C; (reply) [Raisbeck] 1513—C
VENTRICULAR PUNCTURE: See Brain
VENTRICULOGRAPHY: See Brain
VERNES Resorcinol Reaction: See Tuberculosis
VERRUCA, treatment, suggestion, [Bloch-Heim] 235
treatment, trichloroacetic acid, [McLaughlin] 1605—ab
VERTEBRA: See Spine
VERTIGO, 145
aural, intracranial division of auditory nerve for Ménière's disease, [McKenzie] 2104—ab
tinnitus and, 645
VETERANS: See also Soldiers; Spanish-American War
Administration (allergy unit) 23; (annual report) 548
Administration hospitals, ★784; (A. M. A. Committee on Legislative Activities report) 1914
blinded, care of, England, 1745
diabetes in ex-service men, [Matz] ★2214
epilepsy (traumatic) in ex-service men, 934
legislation, 1176; 1180
medical care (free) for, 1019
medical service, American Legion resolution on change in control, 2075
wounded, provision for, England, 54
VETERINARIANS, women, Germany, 2082
VETERINARY help for animals in Abyssinia, 1214
pathology, pioneer of, 392
VINCENT'S Serum: See Streptococcus infections
VIOFORM: See Trichomonas vaginalis vaginitis
VIOSTEROL, high potency; vitamin B_1 and G content, Council statement, 1735
in oil-Sperti process, [Rider & others] ★452
Treatment: See Arthritis, chronic
VIRILISM: See also Morgagni's Syndrome
ovarian tumors causing, [Schiller] 965—ab
VIRUS: See also Influenza; Meningitis; Poliomyelitis; Spotted Fever; Typhus; Yellow Fever
cancers, 717
disease, symposium on, Ohio, 1577
in etiology of skin diseases, 1022
titrating antiviral serums against virus suspensions, 138
VISCERA: See also Organs
tumors induced with hydrocarbons, [Ilfeld] 2101—ab
VISION: See also Blindness; Glasses
acuity, measuring, 1593
conservation classes, 2078
conservation Institute on, New York, 1321
disturbances after ventriculography, 2072—E
effects of occipital lobectomy on, [Spence] 2199—ab
survey, Chicago, 928
testing devices, Betts Ready to Read Tests, 147
testing, optometrists and ophthalmologists, 926—E
testing, use of artificial light, 2093
VISSCHER-BOWMAN Method: See Pregnancy diagnosis
VITAL STATISTICS: See also Population
birth rate and income tax, England, 2247
birth rate falling, England, 717; 2016
birth rates, France and Germany, 225
Death Rate: See also Accidents; Alcoholism; Appendicitis; Automobile accidents; Diphtheria; Maternal mortality; Tuberculosis; Typhoid; etc.
death rate, record low, New York City, 546

VITAL STATISTICS—Continued
death rate, Tokyo, 2173
death rate, U. S., 1212; 1324; (Tennessee) 1323; (Washington) 1669; (Kentucky) 1825
Germany, 1932
morbidity among unemployed, Massachusetts, 472
Mortality of Physicians: See Physicians, deaths
of New York, 1927
of Wisconsin, 1323
VITAMIN A: See also Carotene; Cod Liver Oil
A and D in cooked and fresh foods, [Coward] 660—ab
A and superficial keratitis, [Stocker] 2113—ab
A deficiency among Iowa children; dark adaptation test, [Jeans & Zentmire] ★996
A deficiency and congenital atresia of bile ducts, [Altschule] 573—ab
A, effect on diabetes mellitus, [Ralli & others] ★1975
A in urinary tract lithiasis, 1172
A, new sources and their uses; value of old Chinese remedies, 1108
A, prophylactic and therapeutic claims permissible, by Council, 1733
A utilization, rôle of bile in, 709—E
A. M. A. Cooperative Committee on, 1173; 1187
advertising to laity, Council statement, 1732
B and loss of appetite, 1710—ab
B (complex), claims permissible by Council, 1733
B complex, third factor, [Block] 881—ab
B Therapy: See Anemia
B_1 and G in malt preparations with cod liver oil and viosterol, Council statement, 1735
B_1 deficiency, tissue oxidation in, [Rydin] 170—ab
B_1 in crural neuritis, [Hesse] 1614—ab
C: See also Acid, cevitamic
C and chlorophyll, 1315—E
C, bactericidal power and antitoxic action, [von Gagyi] 1237—ab
C, claims permissible by Council, 1733
C counteracts effects of thyroxine, [Schäfer] 1861—ab
C deficiency in rheumatic fever, [Rinehart] 157—ab
C deficiency, pathologic pigmentations, [Hoff] 1048—ab
C, effect on blood picture, [Eufinger] 1236—ab
C in Urine: See Urine
C requirements in pregnancy, [Neuweiler] 582—ab
C, resorption, bile effect on, [Klodt] 2036—ab
C Therapy: See Addison's Disease
content of canned pineapple juice, [Guerrant] 2196—ab
content of foods in child's diet, [Fellers] 495—ab
Council acceptance of preparations, how much clinical data required before, 1806
D: See also Cod Liver Oil; Viosterol
D and parathyroid hyperplasia, [Quick] 871—C
D, claims permissible by Council, 1733
D, crystalline, antirachitic value, [Lewis] 2033—ab
D deficiency, hyperparathyroidism, [Wilder & Howell] ★427
D, deformed bones in spite of, 704—ab
D Milk: See Milk
D Therapy: See Arthritis, chronic; Rickets; Tuberculosis
deficiency and phlyctenular disease, [Redding] 499—ab
deficiency in adult, [Haden] ★261
E and abortion, [Shute] 747—ab; 1768—ab
E, chemistry, 1496—E
E, clinical experiences with wheat germ oil, [Watson] 1126—ab
E, no preparations accepted by Council, 1734
G deficient diet, changes in rats on, [Smith] 252—ab
hormones and, 1748
hypervitaminosis in country children, [Ball] 2202—ab
VITAMIN—Continued
insurance in winter, 1366—ab
status of certain questions, Council statement, 1732
therapy, shotgun, 1172
VITILIGO: See also Leukoderma
cause; treatment, 1114
VIVISECTION: See Animal Experimentation
VOCAL CORDS: See also Larynx
cancer, 727
VOLKMANN'S Ischemic Contracture: See Contracture
VOLUNTARY Euthanasia Legalization Society, 224
VOMITING: See also Nausea; Sea Sickness
antiemetic combination, 2256
functional, 2180
of Blood: See Hematemesis
VULVA: See also Clitoris
cancer, relation to penis cancer, [Barringer] ★23
leukoplakia, kraurosis, and lichen planus, [Hunt] 1857—ab
Pruritus: See Pruritus
VULVOVAGINITIS: See Trichomonas

W

W. D. S. Pills, 1111—BI
W. P. A.: See Works Progress Administration
WALKING downstairs in heart disease, [Bishop] 401—C
March Foot: See Foot
WALNUTS, allergic synovitis from eating, [Lewin & Taub] ★2144
WAR: See also Army; Military; Soldiers
Air Attacks: See Aviation
Association for the International Protection of Humanity, 1828
Conference on Laws of Warfare, cooperation with International Red Cross Committee, 475
Pensioners: See Pensioners
Spanish-American: See Spanish-American
treatment of late bone inflammations of, [Sarroste] 580—ab
Veterans: See Veterans
WARTS: See Verruca
WASSERMANN Test Fast Syphilis: See Syphilis
WATCH, wrist watch straps, dermatitis from, 1738—E
WATER: See also Baths; Drowning; Hydrology; Swimming
Heavy: See Deuterium
in Blood: See Blood
Injection: See Tuberculosis, Pulmonary, hemoptysis
intake and reduced cooling powers, [Gregory] 2034—ab
leptospira in holy water font possible rôle in jaundice, [Willett & others] ★1644
metabolism, effect on epilepsy, 1412
Mineral: See Mineral Waters
pollution of streams, Illinois, 1100
pollution, states act to control, 715
supply of Vienna, 479
tolerance test in hepatic diseases, [Adlercreutz] 1694—ab
Underwater Exercises: See Crippled; Paralysis
WATERHOUSE-FRIDERICHSEN SYNDROME, [Aegerter] ★1715
WEB: See Larynx
WEIGHT: See Body weight
WELDING: See also Oxyacetylene
rods, electrical, industrial hazards, 1590
WERTHEIM'S Operation: See Uterus cancer
WEST, NICHOLAS R., 233—BI
WEST, OLIN, commendation, 1919
WEST-DAKIN Liver Fraction: See Anemia, Pernicious, treatment
WESTERN ELECTRIC Audiphone, 1386
WHEAT Germ Oil: See Vitamin E
Pearls of Wheat, 1009
whole, iron available in, [Vahlteich] 1043—ab
WHEY Cultures: See Bacillus acidophilus
WHITE Birch Brand Tomato Juice, 1387
WHOOPING COUGH, anesthesia (inhalation ether) in, 147; (reply) [Patterson] 1116
blood counts in, [Begg] 422—ab
etiology, virus-free Haemophilus pertussis, [Shibley] 324—ab
WHOOPING COUGH—Continued
immunization, [Kendrick] 738—ab; 2255
immunization of tetanus and, not incompatible, 148
WIDAL Test: See Typhoid
WILKINS Tea Orange Pekoe, 782
WILKINSON'S Ointment: See Ulcer, crural
WILLARD'S Tablets, 143—BI
WILLIAMS Camphorated Mustard Cream, 143—BI
WILSON'S Adrenal Cortex Extract: See Addison's Disease
WINTER Itch: See Pruritus hiemalis
WIRE Sutures: See Sutures
WISCONSIN Maid Brand Oleomargarine, 1987
WOLFF Tape Test: See Tuberculin
WOMEN, professional, Germany, 2082
WONDER Overhaul Tonic, 63—BI
WONDERFUL Dream Salve, 1111—BI
WOOD Alcohol: See Methyl Alcohol
eruptions in lumber workers, 2092
WORDS AND PHRASES: See Terminology; under Medicolegal Abstracts at end of letter M
WORK: See also Industrial
camps, amenorrhea in girls in, Germany, 1747
diets in relation to, 139
WORKMEN: See Industrial; Unemployed
WORKMEN'S COMPENSATION ACTS: See also under Medicolegal Abstracts at end of letter M
medical relations under, 1181
state legislation, 1177; 1180
WORKS PROGRESS ADMINISTRATION (venereal disease campaign) 1102; (medical service for employees) 1175; 1179; (bureau for physically handicapped) 1577
WORMS, Horsehair: See Gordius robustus
WOUNDED: See Veterans
WOUNDS: See also Heart
infected, cod liver oil or glycerin treatment, [Tumanskiy] 260—ab
infected, use of azochloramid in, [Kennedy] 1231—ab
Stab: See Heart; Precordium
Surgical: See Stomach; Thyroidectomy
treatment, cod liver oil, [Iost] 586—ab; [Tennent] 2109—ab
Zipper closure: See Stomach surgery
WRIGHT, ALMROTH, honored, 1829
WRIGHT Stain: See Erythrocytes
WRIST, traumatic aneurysm of, 318
Watch: See Watch
WRITING: See Handwriting; Prescriptions
WRYNECK: See Torticollis

X

XANTHINE, research by George Hermann et al., [Decherd] 483—C
XANTHOMATOSIS, [Madsen] 1774—ab
metabolism in lipoidosis, [Raeder] 1240—ab
X-RAYS: See Roentgen Rays

Y

YALE University collection of brain tumors, 1901—E
YAWS: See Frambesia
YEAST Infection: See Torulosis
ingested, sensitivity to, [Biederman] ★31
Therapy: See Anemia
YELLOW FEVER and geography, 2132—ab
in laboratory personnel, 890—ab
vaccination, 477
vectors, 1981—ab
virus, inactivated, as immunizing agent, [Gordon] 1950—ab
volunteer, Levi E. Folk, dies, 634
YELLOW MERCURIC OXIDE: See Mercury

Z

ZENO, ARTEMIO, death, 1510
ZINC, effects of iodine followed by, on tissues, 1594
Ionization: See Hay Fever; Trachoma
nutritional significance, 1011—E
oxide factories, arsine intoxication in, Netherlands, 2019
ZIPPER closure of stomach surgical wound, [Strauss] ★285

AUTHOR INDEX

In this Index are the names of the authors of articles which have appeared in The Journal, the names of those who have read papers before Societies as published in The Journal and those whose articles have been abstracted in the Current Medical Literature Department. The * preceding the page reference indicates that the article appeared in full in The Journal. For subject index see page 2271.

A

Aalkjær, V., 1958
Abbott, W. D., *2129
Abbott, W. O., *16
Abernethy, T. J., 880
Abraham, A. L., 336
Abrahamsen, D., 426
Abrahamsen, H., 2036
Abramson, L., 968
Abrumyants, G. N., 84
Abt, A. F., 329
Adair, F. L., *1441
Adams, M., 2192
Adinolfi, G., 964
Adler, E. L., *2054
Adlercreutz, E., 1694
Adlersberg, D., 1432
Adson, A. W., *360, 1425, 2103
Aegerter, E. E., *1715
Africa, C. M., 1605
Aguirre, R. C., 1429
Aird, R. B., 1126
Akelaitis, A. J. E., 657
Albrecht, H., 425
Alcock, N. S., 2265
Alexander, H. L., 1229, 1229
Alke, 1431
Alldredge, R. H., *1252
Allen, A. A., *780
Allen, E. V., 157
Allodi, A., 1692
Alpers, B. J., 419
Alt, H. L., 1220
Altnow, H. O., 159
Altschul, A., *1380
Altschule, M. D., 162, 573
Ammon, R., 966
Amoss, H. L., *1078
Andersch, M., 416
Andersen, T. T., 1955
Anderson, A. F., 1025
Anderson, G., 1604
Anderson, J. A., 1043
Anderson, N. P., 740
Anderson, R. K., 1603
Andreasen, A. T., 961
Andreucci, M., 963
Andrewes, C. H., 960
Andrews, G. C., 418
Andrus, E. C., 157
Angus, L. R., 1599
Anrep, G. V., 422
Anselmino, K. J., 585, 1693
Antonucci, C., 1770
Apperly, F. L., 1234
Aravantinos, A., 661
Araya, R., 81, 501, 2036
Arkin, A., *587
Armstrong, B., 2195
Armstrong, C., 1424
Armstrong, H. G., *1347
Arneson, A. N., 1949
Arnold, C. H., 496
Arnot, P. H., 1340
Arnott, W. M., 2200
Aronsohn, H. G., 1948
Asher, L., *1917
Asher, M., 1123
Ask-Upmark, E., 1138, 1957
Atchley, F. O., 1848
Atkinson, A. J., *515
Aufranc, O., 1045
Averbuck, S. H., 951
Ayres, S., Jr., 740

B

Baar, H., 663
Babey, A., *462
Babtchine, I. S., 1235
Bagdasarov, A., 1957
Bailey, G. N., 1608
Bailey, H. A., 339
Bailey, O. T., 250
Bainbridge, W. S., 2197
Baird, J. B., 579
Bakhsh, I., 961
Balázs, J., 751
Ball, W. A., 2202
Ballenger, E. G., 1220
Baltz, J. I., 570
Barach, A. L., 572, 725
Baranov, V. G., 1050
Baráth, E., 752
Barbera, G., 964
Barclay, I. B., 579
Bardwell, K., 335
Barenberg, L. H., *1256
Baretz, L. H., *980
Barglowski, D., 1861
Barker, M. H., *762
Barker, N. W., 246
Barker, P. S., 324
Barnacle, C. H., *2046
Barnard, J. H., 419
Barnes, R. W., 743
Barney, J. D., 2109
Báron, A., 343
Barr, D. P., 1851
Barringer, B. S., *21
Barron, L. E., 329, 413
Bartholomew, R. A., 2101
Bartleman, E. L., 2199
Bartlett, R. W., *615, *1386
Bartlett, W., Jr., *615, *1386
Barton, J. C., *197
Bassler, A., 161, *1965
Bastedo, W. A., *85, 642
Basu, C. C., 1858
Battle, R. J. V., 1608
Bauer, J., 967
Bauer, K. H., 581
Bauerlein, T. C., 1229
Baumberger, J. P., 335
Beard, H. H., 74,332
Beck, C. E., 75
Beck, E. C., 572
Beckh, W., 570
Beecher, H. K., 968
Beer, E., *1063
Begg, N. D., 422
Behnke, A. R., Jr., 1038, 2104
Belinow, S., 168
Bell, A., *441
Bell, G. E., 2109
Belote, G. H., 2031
Beluffi, E. L., 661
Benda, R., 1235
Bender, E., 2115
Bender, M. B., 1949
Benedict, E. B., 155
Bener, A., 1612
Bengolea, A. J., 964
Bengtson, I. A., 163
Bennett, A. E., 1523
Bennett, J. H., *434
Benning, C. H., 1423
Berdel, W., 169
Berg, A., 749
Bergemann, E., 1774
Berger, L., 1949
Berger, R. A., 249
Berger, W., 2205
Bergey, D. H., 483
Berkman, J. M., *2042
Berliner, K., 654
Berman, L., 1754
Berner, O., 1864
Bernhard, A., 1421
Bernhard, F., 662
Bernheimer, L. B., *1980
Bernstein, M., *532
Bernstine, J. B., 1037
Bertola, A., 1692
Bértola, V., 1047
Best, C. H., 2111, 2194
Best, R. R., 337
Besta, B., 503
Bettman, R. B., *1376, 1420, *1728
Beumer, H., 258
Biederman, J. B., *31; *2236
Biegeleisen, H. I., 2032
Biemond, A., 169
Bierman, W., *1158
Bierring, W. L., 1097
Bigger, I. A., 499
Bilimann, G., 2268
Binet, L., 962
Binger, M. W., 415
Binks, W., 2109
Birk, B. J., 745
Birt, A. R., 956
Bisgard, J. D., *1639
Bishop, L. F., 401
Bishop, L. F., Jr., *462
Biskind, L. H., 340
Bizzozero, E., 964
Blache, J. O., *919
Black, W. A., 254
Blackford, L. M., 1044
Blaisdell, E. R., 1853
Blake, F. G., 1853
Blalock, A., 420, 958
Blinov, N., 343, 1771
Bloch, L., *1156
Block, R. J., 881
Blocksom, B. H., Jr., 325
Blodgett, W. E., *2121
Bloom, M. S., *1991
Blotner, H., *1970
Blum, B. B., *1701
Blumberger, K., 584, 1430
Blumenthal, B., 420
Blumstein, G., 1689
Boas, E. P., 1952, *2238
Boas, I., 582
Boas, L. C., *678
Bock, A., 1136
Bock, K. A., 582
Bockus, H. L., 2263
Bøggild, D., 344
Böhler, L., 2267
Boeters, H., 663
Boggess, T. S., 74
Bolgert, M., 2035
Bolton, B., 1609
Bonar, B. E., 73
Bondar, H. K., 333
Bondarenko, E., 1957
Bonell, W., 752
Bonney, V., 570, 1954
Bonorino Udaondo, C., 580
von Bonsdorff, B., 2268
Booth, G., 1763
Boothby, W. M., 2192
Borst, W., 1862
Bothe, F. A., 2103
Boulez, N., 423
Bousfield, G., 660
Bowen, B. D., 572, 1233
Bower, J. O., *1151
Bowing, H. H., 654
Boyce, F. F., 1766
Boyd, E. M., 1127
Boyd, M. J., 959
Braasch, W. F., *1343
Brack, C. B., 249
Brain, W. R., 1691
Bram, I., 335
Branch, A., 331
Brandaleone, H., *1975
Bresci, L., 2266
Breuer, M. J., 421
Brickner, R. M., 1232, *2117
Briggs, J. F., 161
Briskas, S. B., 256
Broadhurst, J., 1950
Brock, S., *441
Brockway, A., *1635
Bronaugh, W., 1856
Broos, J., 968
Brown, C. P. (El Paso, Tex.), 1221
Brown, C. P. (Philadelphia), 162
Brown, G. E., 246, *353, 951, 1425
Brown, L. T., 742
Brown, M. H., 334, 1422
Brown, P. K., 400
Brown, R. G., 2265
Brown, W. L. (El Paso, Tex.), 1221
Brown, W. L. (London), 579
Browne, D., 746
Bruckheimer, R. M., 2102
Brühl, R., 664
Bruenn, H. G., *1080
Brugsch, H., 1772
de Bruin, M., 1434
Brun, J., 165
Bruner, H. D., 254
Bruner, R. C., 248
Bruns, H., 2115
Bruns, O., 884
Brunschwig, A., 737
Brunsting, L. A., *1533
Bucher, A., 962
Buckley, A. C., 1951
Budelmann, G., 752, 1431
Bühler, K., 169
Bülbring, E., 1609
Bulger, H. A., 1851
Bull, P., 1050
Bullock, E. S., *297
Bumpus, H. C., 1856
Bundesen, H. N., *115
Burdick, C. G., 75
Burgess, N., 164
Burke, F. J., 747
Burket, L. W., *1719
Burman, M. S., 1601
Burn, C. G., 656
Burn, J. H., 1609
Burnet, F. M., 962
Burns, E. L., 951
Burwell, C. S., 958
Bustos, F. M., 749
Bustos Morón, R., 81
Butsch, W. L., *2227
Butt, H. R., 955, *994
Buxbaum, H., 1761
Bystritskiy, Y. L., 2206

C

Cade, C. C., 1607
Cadness, B. H. E., 2196
Caeiro, J. A., 1611
Cahill, J. A., *1625
Cain, A., 1611
Caldwell, G. A., 2264
Cameron, G. R., 1427
Camp, J. D., 246, 2198
Campbell, A. M., 1761
Campbell, M. F., *193, *2232
Campbell, R., 2266
Campbell, W. R., 2194
Canall, G., 1135
Cannaday, J. E., 339
Cannon, A. B., *2133
Cantarow, A., 155, 156
Cantril, S., 420
Capdehourat, E. L., 1692
Capps, R. B., 159
Caprio, F. S., *687
Card, J., *595
Cardis, F., 2203
Carlson, F. G., *1164
Carmichael, E. A., 1131, 1609
Carrié, C., 1237
Carrington, W. J., *2098
Carter, H., 2199
Carter, H. A., *2063
Cary, W. H., *2221
Casparis, H. R., *2207
Cass, J. W., Jr., 1129
Cassidy, H. G., *452
Castellani, A., 79
Castex, M. R., 1692
Castleman, B., 1762
Caulfeild, A. H. W., 334
Caulk, J. R., 577
Cavalli, G. F., 2035
Cazzamali, P., 883
Cervini, P. R., 1429
Chakraborty, R. K., 1859
Chamberlin, W. B., 1600
Chambers, H., 1428
Chand, A., 2199
Chang, D. K., *1386
Chang, H. C., 2112
Chapman, E. M., 559
Charlin C., C., 257
Chatterjee, H. N., 1858
Chéchan, 2266
Chéhale, C., 1341
Chein-Cheifitz, F. B., 1955
Ch'en, K. C., 2112
Cheney, G., 331, *683
Chevillon, G., 165
Chew, W. B., 1123
Childe, A. E., 2105
Chinn, A. B., 78
Chipman, S .S., 879
Chiray, M., 2035
Chittenden, G. E., *602
Chorine, V., 1047
Chou, S. K., 2112
Chown, B., 1608
Christensen, S., 2036
Christoffersen, W. G., 1419
Cicardo, V. H., 166
Clark, C. P., 1125
Clark, G. L., 1766
Clark, H. C., 2192
Clark, J. H., *370
Clark, M. M., *447
Clarke, W., *767
Clay, R. D., 1133
Cleland, J. B., 961
Clock, R. O., 338
Coady, H. F., 1422
Coburn, C. E., *1264
Coca, A. F., 957
Cockayne, E. A., 660
Cogswell, H. D., *537
Cohen, L., 417
Cohen, M., 1521
Cohn, M. L., 1951
Cole, H. N., *464
Colebrook, L., 340
Colella, R., 335
Collens, W. S., *678, 1849
Conant, N. F., 1039
Condorelli, L., 1047
Cone, W., 655
Conklin, C. B., 577
Conrad, H., 1431
Constantinovich, S. K., 572
Conte, M., 2203
Contreras, M. R., 1770
Conway, J. H., *1153
Conwell, H. E., *1252
Cooke, R. A., 419
Coonse, G. K., 1045
Cooper, C. N., 324
Cooper, G. A., 418
Copeman, W. S. C., 1133
Corbus, B. C., 743
Cormia, F. E., 1601
Cornbleet, T., *2144
Corper, H. J., 1951
Corrigan, J. C., *1088
Corsello, J. N., 2102
Coryllos, P. N., 2262
Costello, J. P., 1604
Costello, M. J., 498
Costello, R. T., 1849
Costen, J. B., 251
Cotte, G., 423, 423
Cotti, L., 1431
Coulter, J. S., *209, *2063
Coveney, M. F., 422
Cowan, A., 2102
Coward, K. H., 660
Cowper, R. B. G., 1426
Craig, W. M., 1425, 2103
Cramer, W., 1768
Crandall, L. A., 416
Craven, E. B., Jr., *1383
Craver, L. F., 952, *1802
Crawford, J. H., 2201
Creswell, S. M., *1384
Crohn, B. B., *1
Crowe, T. J., 1570
Cullen, T. S., *895
Culler, A. M., 2104
Culpepper, W. L., 1040
Cumming, H. S., 1044
Cumming, R. E., *602
Cunningham, D. R., *1791
Curnen, E. C., 1125
Curran, J. A., *753
Curschmann, H., 166
Curtis, G. M., 329, 413
Curtis, H. C., 2032
Cuthbertson, D. P., 1608
Cutler, E. C., 725
Cutler, J. W., *1366
Cutter, R. D., *1006
Cutter, R. K., *1250
Cutter, W. D., 1392
Cutting, W. C., 161
Czunft, W., 751
Czyżak, J., 2116

D

D'Abreu, A. L., 882
Dack, G. M., *7
Daels, F., 1239
Dahl-Iversen, E., 1138
Dahr, P., 257
Daley, F. H., 2105
Dalsgaard, S. C., 1138
Damerow, A. P., 1951
Dameshek, W., 1837, 2177
Dandy, W. E., 76
Danelius, G., 337
Daniels, A. L., 2196
Darling, D., 245
Darling, R. C., 1037
D'Aunoy, R., *1642
Davenport, G. L., 420
David, N. A., *405

David, V. C., ★1875
Davidoff, L. M., 333
Davidson, A. M., 956
Davidson, L. S. P., 1954
Davidson, L. T., 879
Davidson, S., ★1975
Davidson, W. D., ★2237
Davies, M. E., 332
Davis, A. A., 1428
Davis, D. M., 743
Davis, G. G., ★1359
Davis, J. S., Jr., 1233, ★1448
Davis, L., ★350
Davison, C., ★441
Dawson, M. H., 1764
Deardorff, M. F., 2196
DeBakey, M., 1522
Debré, R., 495, 1134
Decherd, G. M., 483
Decherd, G. M., Jr., 2107
Deckner, K., 581
DeGowin, E. L., 416
Delarue, J., 1860
de Leon, W., 1605
Demole, M. J., 341
de Monte, A. J. H., 2109
De Navasquez, S., 339
Dennie, C. C., 657
Depp, M. E., 84
Derman, G. L., 2116
Derow, H. A., 162
de Silva, E. B., 957
Desjardins, A. U., ★690, 2107
Desplas, B., 165
de Takáts, G., 871, ★1003
Devine, H. B., 1131
Dharmendra, 2200
Díaz Bobillo, I., 1611
Dick, W., 1613
Dickinson, R. L., 144
Dickson, E. C., ★777
Diefenthaler, H., 1237
Diehl, F., 342
Diehl, H. S., ★1354
Dinkler, G., 1432
Doan, C. A., 325, ★609
Dobbs, R. H., 164
Dobreff, M., 1693
Dochez, A. R., 1852
Doepp, M., 1771
Doles, H. M., 421
Dolff, C., 504
Domenech, F., 580
Dorff, G. B., 1111
Doroklova, O. N., 259
Douglas, A. H., 1421
Downes, J., 155
Dragišić, B., 1430
Dragstedt, L. R., ★7
Drake, C. B., ★1005
Drash, E. C., 1607
Drinker, C. K., ★669
Dudkevich, E. A., 2116
Dufourt, A., 165
Dukes, C., 2199
Dulcin, M., 1957
Duncan, C., 2102
Dunn, C. W., 1042
Dunn, R. D., 960
Dutcher, R. A., 2196
Dutrey, J., 1525
Dworzak, H., 751
Dyckerhoff, H., 83
Dyer, R. E., 163
Dyggve, L. P., 1434, 1774
Dyke, C. G., 333

E

Eastwood, C. G., 961
Eaton, F. B., 78
Ebaugh, F. G., 1571, ★2046
Ebbehøj, K., 1958
Ebhardt, K., 1135
Edelmann, A., 584
Edison, S. M., 1421
Edwards, E. A., 1688
Edwards, J. W., ★2058
Effkemann, G., 1862
Ehlert, H., 167
Ehrström, M. C., 1434
Ehrström, R., 664
Eichert, H., ★1652
Eklund, C. M., 955
Elder, O. F., 1220
Eldering, G., 738
Eley, R. C., 1422
Ellersieck, D., ★1541
Elliot-Smith, A., 164
Ellis, R. W. B., 1769
Ellison, R. T., 330
Ellsworth, H. C., 2197
Ellsworth, R., ★284
Elton, N. W., 952
Elwood, E. S., 1395
Emery, E. S., Jr., 1421
Emge, L. A., 960
Enders, J. F., 331
Engel, D., 749
Engel, J., ★1879
Engel, W. J., 576
Engelbreth-Holm, J., 344
Engelhart, E., 2116
Epstein, B. S., 1947
Epstein, E., ★769
Epstein, S., 1427
Epstein, S. H., ★1527
Erbslöh, J., 1238
Ercklentz, B. W., 424
Erf, L. A., ★609, ★1783, 1952
Erickson, B. N., 574
Erös, G., 1614
Etcheves, J. C., 2114
Ettelson, L. N., 575
Eufinger, H., 1236
Everson, G. J., 2196
Everts, W. H., ★18, 1232
Ewalt, J. R., ★2046
Ewert, E. E., 659
Exner, M. J., ★488, ★767
Eyvin, V. G., 1433

F

Fairchild, R. D., ★2121
Fales, W. T., ★1377
Falker, I. D., 958
Falls, F. H., ★271
Faltitschek, J., 1693
Fantl, P., 1137
Fantus, B., ★375, ★1728, ★2144
Farber, S., 160
Farquharson, R. F., 76
Farrell, J. T., Jr., ★92
Fatzer, H., 1134
Faulkner, H. L., 575
Faust, E. C., ★461
Fauvet, E., 1863
Favelukes, J., 257
Favorite, G. O., 1123
Fedorov, P. S., 2268
Feil, H., 1229
Feinberg, S. C., 1687
Feldman, H., 1761
Fellers, C. R., 495
Felsen, J., 2191
Fenton, R. A., ★1775
Fernán-Núñez, M., 1850
Ferraro, A., 1129
Ferris, E. B., Jr., 159
Fetterman, J. L., ★26
Fichman, A. M., 1679
Fidler, H. K., 737
Field, H., 1041
Filatov, A., 84, 1771
Finder, J. G., 1953
Findlay, G. M., 2265
Fine, M. J., 73
Finkelman, I., 156
Finlayson, M. H., 1770
Fischer, J., 1432
Fist, H. S., 1331
Fitzgerald, J., 570
Flaxman, N., 144
Fleckseder, R., 168
Fleischhacker, H., 663
Fleischner, F., 1861
Fletcher, A. A., 2194
Flexner, S., 1041
Flinn, L. B., 251
Flood, C. A., 77, 1045
Fluhmann, C. F., 1426
Flusser, E., 583
Foerster, H. R., 418
Foerster, O. H., 418
Fogelson, S. J., 1603
Foisee, P. S., 1045
Foley, E., 245
Fomina, P. I., 965, 1050
Fonio, A., 2113
Fonseca, G., 1525
Fontaine, R., 883
Forbes, H. S., 1038
Forsberg, R., 1864
Foshay, L., ★2141
Fowler, J. G., 572
Fraenkel, E. M., 748, 1042
Francisco, C. B., 1851
Franke, F. E., ★507
Franke, K., 585
Franseen, C. C., ★1373
Frazier, C. H., 2103
Freeman, H. E., ★1261
Freeman, W. (Boston), 1947
Freeman, W. (Washington, D.C.), ★96
Freiman, M., 1608
Fretwurst, F., 167
Freudenthal, P., 344
Freund, E., ★1268
Frick, G., 1048
Fricke, R. E., 654
Fried, B. M., 737, 1037
Friedl, F., 2115
Friedman, G., 957
Friedman, I., 1848
Friedman, M., ★1879
Friedmann, M., ★1051
Friedrich, H., 1049
Frola, E., 1430
Frost, J. G., ★1708
Frost, T. T., 1847
Fucci, N., 2113
Fuchs, G., 2115
Fülling, G., 1772
Fülöp, J., 752
Fulton, J. F., 2199
Funsten, R. V., 1690
Furlow, L. T., 1854

G

Gaehtgens, G., 1236
Gage, M., 1425
von Gagyi, J., 1237
Gál, F., 586
Galan, J. C., 1525
Galland, W. I., 658
Galloway, C. E., ★505
Gamaley, E. P., 256
Garcia, E. Y., 1605
Garcia, O., 1855
Garland, L. H., 960
Garry, R. C., 1132
Garver, H., 2261
Garvey, P. H., 880
Gay, L. P., ★969
Geiger, A. J., 572
Geiger, J. C., 1339
Geill, T., 504
Genet, L., 2266
de Gennes, L., 1860
Gepfert, J. R., 1948
Gerber, I. E., 1949
Germond, R. C., 1691
Gerundo, M., 1851
Geschickter, C. F., 1851
Gesell, A., ★1146
Gettelman, E., ★207
Ghormley, R. K., 157
Gibbs, A. J., 578
Gibson, H. J., 746
Giesen, W., 1526
Gilbert, C. L., 1123
Gildea, E. F., 1603
Gill, A. B., ★40
Gillespie, M., 80
Gilmore, E. A., 1206
Gilpin, S. F., ★1722
Ginés, A. R., 581
Ginsberg, H. I., ★1631
Ginsburg, T. M., ★1779
Gitt, J. J., ★1535
Gladen, R. G., 573
Glatzel, H., 582
Glauner, R., 1526
Godel, R., 1341
Goeters, W., 966
Goethals, T. R., 1606
Goldberg, B. I., 74
Goldberg, M. B., 573
Golden, R., 2031
Goldhamer, S. M., 1687
Goldkorn, L., 1134
Goldman, D. G., 2268
Goldman, I. B., 2193
Goldman, J. L., 2193
Goldsmith, A. A., ★1797
Goldstein, A. E., 576
Goldstein, D. W., ★1659
Goldwater, L. J., 1603
Golob, M., ★1725
Gómez, F. D., 581
Goñalons, G. P., 580
Gonzales, T. A., ★286
Gonzalez, H. D., 1430
Goode, G. P., ★452
Goodfellow, D. R., 578
Goodman, J., ★1000
Goodman, M., 1605
Goodman, M. H., 1688
Goodrich, B. E., 326
Goodwin, W. H., ★2209
Gorbouncova, Z., 165
Gordon, B., 417
Gordon, F. B., ★2037
Gordon, J. E., 1950
Gordon, W., 415
Gotsch, K., 1613, 1863
Gottdenker, F., 1432
Gottesman, J., ★1895
Gottlieb, J., 743
Gottlieb, J. S., 1125
Gough, A., 79
Gould, S. E., ★1631
Gowen, G. H., 2105
Goyle, A. N., 578
Grad, H., 570
Graham, G. D., 573
Graham, H. C., 1130
Grain, R., 2112
Gram, H. C., 586
Grand, M. J. H., ★1256
Granzow, J., 750
Grauer, R. C., 158
Graves, R. C., 2263
Gray, H. K., ★916
Gray, R. M., 160
Gray, S. H., ★919
Green, A. A., 1422
Green, A. H., 2261
Green, W. T., 1601
Greenbaum, S. S., 940
Greene, D., 1420
Greenfield, J. G., 1131
Greenhill, J. P., ★606, 871, 1229
Greenspon, E. A., ★266
Gregory, H. S., 1854
Gregory, R., 324
Gregory, R. A., 2034
Greiner, W., 81
Grieshaber, H., 1433
Griffin, M., ★1343
Griffiths, G. J., 1610
Grigorenco, V., 165
Griswold, R. A., ★1054
Grønn, R., 1240
Gróh, E., 1049
Gross, L., 1037
Grove, E. F., 957
Grüneberg, B., 585
Grüneberg, T., 2115
Grüninger, U., 1692
Gruskin, B., 953
Gudin, M., 1860
Güçhan, M., 167
Guerrant, N. B., 2196
Guglucci, A., 1860
Guild, C. St. C., 739
Gulbin, O., 343
Gumpert, T. E., 2034
Gundrum, L. K., 161
Gunsett, 883
Gurd, F. B., 1126
Gurewitsch, L. I., 84
Gurney, R., 1763
Guthmann, G., 1611
Gutierrez, R., ★183
Guy, C. C., ★1708
Gwathmey, J. T., 1230
von György, E., 82
György, L., 2114

H

von Haam, E., ★1642
von Haberer, H., 502
Haden, R. L., ★261
Hadley, M. N., ★537
Häcker, W., 749
Häussler, G., 1612
Hagedorn, H. C., ★177
Hahn, P. F., 653
Haim, A., ★1090
Hajkis, M., 1240
Hajna, A. A., 252
Haldeman, K. O., 338
Hall, A. F., Jr., 160
Hall, G. W., ★431
Hallauer, C., 963
Hallberg, O. E., 1050
Hallervorden, J., 167
Hallum, A. V., ★1649
Halter, K., 966
Haman, R. W., 574
Hamburger, W. W., ★902
Hamman, L., 1521
Hampton, A. O., 155, 577, 655
Hanelin, H. A., ★1359
Hanes, F. M., ★2058
Hanflig, S. S., ★523
Hanke, 1049
Hannecart, J., 423
Hansen, A. B., 1774
Hansen, L. P., 881
Hansen, R. A., 163
Hansen-Prüss, O. C., ★2058
Hansmann, G. H., 1849
Hanson, A. M., ★370
Hanssen, P., 884, 884, ★914, 1694
Hardy, G. E. W., ★910
Hare, R., 339
Harker, J. M., 255
Harper, P., 1848
Harris, A., 418
Harris, C. H. S., 1133
Harris, R. I., 741
Harris, S., 1230
Harris, W. (London), 1124
Harris, W. (New York), 75
Harrison, W. T., 1424
Hartman, L. L., 2108
Hartmann, A. F., 416
Hartmann, J., 2205
Hartung, A., ★596
Hartung, E. F., 1233, ★1448
Hashimoto, H., ★1266
Hashinger, E. H., 1339
Haskell, B., 156, ★1248
Hausen, E., 1611
Haverfield, W. T., 413
Hawkins, J. A., 163
Hawley, E. E., 1604
Hawthorne, A. B., ★189
Hays, H., 643
Hazard, J. B., 1045
Hazen, E. L., 2105
Hazen, H. H., 1044
Head, J. R., 159
Heald, C. B., 2265
Healy, J. C., 2105
Heath, C. W., ★1463
Hebald, S., 419
Hecht, A. F., 663
Heck, F. J., 326
Heckscher, H., 1138
Héderer, 341
Heerup, L., 1864
Heinz, T. E., ★7
Heller, H., 748
Helwig, F. C., 958
Henderson, Y., 64
Hendry, J. A., 1610
Henning, N., 2203
Henningsen, E. J., 1342
Henningsen, O., 1612
Henry, A. K., 1132
Henschen, F., 1616
Henson, E. B., 1340
Hepburn, J., 1602
Herbst, R., 341
Herbst, R. H., ★2125
Herkel, W., 1772
Herlyn, K. E., 81
Hermanson, L., 1953
Herrin, R. C., 1762
Herrington, L. P., 952
Herrman, C. S., ★1357
Herrmann, G., 2107
Herrmann, S. F., 881
Herrold, R. D., 659
Hershberg, R., 245
Hess, L., 1693
Hesse, E., 1614
Heuer, G. J., 574
Heyd, C. G., ★1923
Heyman, C. H., ★11
Heymann, W., 1419, ★2050
Heyrovsky, H., 2205
Hibbitts, J. T., 249
Hicken, N. F., 337
Hickman, J., 332
Hiebert, J. C., 1409
Higgins, C. C., 253, 253
Higinbotham, N. L., 75
Hiller, B., 579
Himsworth, H. P., 1610
Hinckley, R. G., ★1354
Hines, E., 161
Hines, E. A., Jr., 951
Hines, L. E., 416
Hinman, E. H., 744
Hinman, F., 1128
Hinsberg, K., 966
Hinselmann, 343
Hippe, H., 1692
Hirsch, S., ★705, ★1562
Hirschlaff, B., 1434
Hirshland, H., 1855
Hirshland, H. C., 1855
Hitch, J. M., ★2130
Hjort, E., 1864
Hobson, F. G., 2035
Hodgson, T. H., 1857
Hoerner, M. T., 333, 418
Hoff, F., 1048
Hoff, H., 2267
Hoffman, W. S., 415
Hoffmann, F., 585
Hoffmann, P. E., 1426
Holbøll, S. A., 426
Hollander, L., ★706
Holmgren, I., 1434
Holten, C., 1774
Holtz, E., 957
Hopf, G., 158
Horan, T. N., 498
Horder, ★1906
Horning, E. S., 1768
Horrax, G., 1125
Horsfall, F. L., Jr., 880
Horton, B. T., 246
Horwitz, A., 1423
Hosen, H., 336
Hosmer, M. N., 496
Hosoi, K., 1425
Houghton, L. E., 80
Hoverson, E. T., 1950
Howard, M. E., ★517, 1853
Howell, L. P., ★427
Howes, E. L., 1045
Howles, J. K., 954
Hubbell, R. B., 881
Hubeny, M. J., 1753
Huber, H. H., 745
Hudson, N. P., ★2037
Huffman, J. W., 157
Huggins, C. B., 325
Hughes, T. P., 1950
Huguenin, P., 2113
Huguenin, R., 501
Hull, W. S., 1853
Hulse, C. R., 329
Humberd, C. D., ★1713
Hummell, F. C., 574
Hundley, J. M., Jr., 249
Hunscher, H. A., 574
Hunt, E., 1857, 2201
Hunt, G. A., ★919
Hunter, D., 255
Hunter, F. T., 1523
Husted, E., 2268
Hutchings, G. W., 959
Hutton, J. H., 1040, 1753
Hyndman, O. R., 324

I

Iglauer, S., 251
Ilfeld, F. W., 2101
Imerman, C. P., ★1085
Imerman, S. W., ★1085
Ingraham, N. R., Jr., 495
Introzzi, A. S., 1135
Iost, V. L., 586
Irving, F. C., 1761

Isaacs, R., 326
Isch-Wall, P., 1341
Isenberger, R. M., 1951
Israel, S. L., ★1698
Ivanissevich, O., 1135
Ivy, A. C., ★515

J

Jackson, A. S., ★1261
Jackson, D., 574
Jackson, D. E., ★357
Jackson, H., Jr., 1037
Jacobs, J., 1112
Jaffé, R. H., 76, 1600
Jameson, E. M., 1037
Jankelson, I. R., 1847
Jarman, T. F., 2195
Javert, C. T., ★529
Jeans, P. C., ★996, ★2066, ★2150
Jensen, B. N., ★177
Jervis, G. A., 1129
Jessop, W. J. E., 2110
Jezler, A., 2266
Johns, A. M., 340
Johns, G. A., ★1541
Johnson, C. M., 1128
Johnson, H. J., ★1776
Johnson, H. L., 1045
Johnson, V. M., ★461
Johnston, F. D., 247
Johnston, M. M., 497
Jones, C. M., 78, 155
Jones, E., 2264
Jones, O. R., 1123
Jordan, W. R., 1231
Jordans, G. H. W., 968
Jordon, J. W., 740
Jores, A., 502, 585, 965
Jorns, G., 1237
Jowett, R. E., 1859
Judd, E. S., 333, 418
Jürgens, O., 883
Juhlin-Dannfelt, C., 260
Jullien, W., 1341
Jungmann, G., 1615

K

Kaake, M. J., 497
Kahlstorf, A., 166
Kaiser, A. D., 958, 1764
Kanfor, I. S., 2206
Kanter, A. E., 234
Kantor, J. L., 1600
Kantorovich, N. V., 572
von Kapff, 166
Kapitza, L., 1136
Kaplan, A., 1040
Kaplan, I. I., 1424
Kapnick, I., 1422
Karadimova, N., 165
Karbacher, P., 1429
Kárpáti, G., 1615
Kárpáti, J., 84
Karrenberg, C. L., 582
Karsner, H. T., ★1445
Karunaratne, W. A. E., 1427, 1428
Katsnelson, S. M., 2116
Katz, A. M., 245
Katz, G., 1432
Katz, L. N., ★902
Katzmann, E. E., 256
Kaunitz, J., 1039, 1679
Kaye, G. W. C., 2109
Kayser, F., 1770
Keeton, R. W., 245
Keilhack, H., 2203
Keining, E., 158
Keith, N. M., 415
Kellar, R. J., 2200
Kelling, D., ★1541
Kelly, E., 324
Kemp, J. E., 880, 954, 1688
Kemp, S., 1955
Kendrick, A. B., 245
Kendrick, P., 738
Kennedy, R. H., 1231
Kepler, E. J., 414, ★1701
Kern, R. A., 1409
Kerr, H. D., 249
Kerr, R. B., 2194
Keschner, M., 1949
Kessel, F. K., 748
Ketron, L. W., 1688
Khorazo, D., 334
Kibler, F. E., 2106
Kickham, C. J. E., 1853, 2263
Kilbourne, N. J., 1606
Kilduffe, R. A., ★2098
Kindel, E. A., 738
Kindler, E., 1612
King, E. L., 577
King, G., 2202
King, S. R., 337
Kinsella, T. J., 1522
Kinser, P., 1690
Kipp, H. A., ★2223
Kirk, E., 586
Kirshbaum, J. D., ★988
Kisch, F., 1613
von Kisfaludy, P., 2115
Kjærgaard, H., 504, 1957
Klaften, E., 584
Klauder, J. V., ★201
Kleiber, N., 1431
Klein, D. L., 2105
Klein, O., 424
Kleindienst, E., 502
Kleiner, I. S., ★1643
Klessens, J. J. H. M., 1526
Klima, R., 1137
Klingmann, T., ★18
Klodt, W., 2036
Klotz, H. P., 1770
Klumpp, T. G., ★1245
Kneeland, Y., Jr., 1852
Knierer, W., 1048
Knipping, H. W., 1525
Knott, E. M., 2196
Koch, F., 341
Koch, K., 1772
Kochergin, I. G., 586
Koenig, E. C., 572
Kohl, C., ★1557
Kolb, H., 257
Koller, T., 963
Komp, W. H. W., 2192
Koopman, J., 958
Kopeloff, N., 1331
Koplin, H., ★374
Kopp, I., ★1527
Koritschoner, R., ★1269
Korns, H. M., 324
Korol, E., 654, 1124
Kosmak, G. W., ★1435, 2089
Kost, G. F. W., 1433
Koucky, R., 336
Kountz, W. B., 1229
Kracke, R. R., 1422, 2101, 2261
Kraemer, M., 1123
Krafft, H., 259
Krarup, N. B., ★177, 884
Krauel, G., 1431
Kraus, E. J., 583
Kraus, J., 1955
Kreidel, K. V., 2261
Krestin, D., 882
Krinsky, C. M., 1125
Krishnaswamy, K. G., 578
Kritschewsky, L. S., 581, 1773
Krohn, L., ★271
Krüger, E., 752
Krumbhaar, E. B., ★286
Krusen, F. H., ★118
Kuder, K., ★885
Kudo, M., ★1266
Küstner, H., 503
Kugelmass, I. N., 1588
Kukhtin, N. K., 260
Kun, H., 1862
Kunath, C. A., 1126
Kunewälder, E., 967
Kunos, S., 1614
Kunstadter, R. H., ★207
Kuntz, A., ★345
Kuré, K., 2204
Kurshakov, N. A., 260
Kurtz, C. M., ★434
Kylin, E., 342, 1434

L

Lackner, J. E., ★271
Lämmli, K. A., 750
Lafuente, A., 580
Laidlaw, P. P., 960
Lamarque, C., 341
Lamb, M. E., ★1075
Lambert, G., 83
Lampé, A. E., 503
Lamy, M., 1134
Lancaster, F. J., ★1383
Lande, H., 332
Landsteiner, K., 1112
Landt, H., 324
Lang, R. S., ★1162; (correction) 1828
Langdon-Brown, W.: See Brown, W. L. (London)
Langer, M. M., 504
Laning, G. M., 498
Lanza, A. J., ★368
Larizza, P., 1431
Larsen, U., 1774
Lauche, A., 2114
Lauda, E., 1239, 2205
Launoy, L., 165
Lauro, A., 1235
de la Viesca, P., 341
Lawrence, C. H., ★983
Lawrence, J. C., 1420
Lawrence, R. D., 340
Laybourn, R. L., 880
Laymon, C. W., 158
Leary, T., 1408, 2194
Le Cam, J., 1692
Lee, D. H. K., 2034
Leech, C. B., ★1895
Lehman, E. P., ★2209
Lehnherr, E. R., 642
Leimdörfer, A., 259
Lemierre, A., 426
Lemoine, A. N., 657
Lenggenhager, K., 2203
Lenke, S. E., 329
Lennette, E. H., ★2037
Lennox, W. G., 954, 2104
L'Episcopo, J. B., 2196
Lerch, A., 583
Leriche, R., 883
LeRoy, G. B., ★431
Leubner, H., 2205
Leverton, R. M., ★1459
Levin, I., 2198
Levin, L., 2263
Levin, O. L., 158
Levine, S. A., 254
Levine, S. Z., 879
Levine, V., ★1544
Levinsohn, S. A., 2253
Lévy, G., 501
Levy, R. L., ★1080
Levy, W., ★1256
Lewin, P., ★2144
Lewis, D., 1851
Lewis, J. M., 2033
Lewis, R. M., ★2054
Lewisohn, R., ★684
Lichtenhahn, F., 1134
Lichtenstein, B. W., ★1057
Liedberg, N., 1616
Liegner, B., 344, 424
Lilienthal, H., 2253
Liming, R. M., 1950
Lindenbaum, I., 1136
Lindskog, G. E., 1848
Lindsley, D. B., 1125
Lisser, H., 573
Little, C. C., ★2234
Litzner, S., 585
Livermore, G. R., 253
Livingstone, H., 332
Lloyd, R. I., 1948
Lockie, L. M., 1233
Loeb, L., 951
Loeffler, L., 2194
Loizeaux, M. C., 332
Loman, J., 1599
Lord, F. T., 1042
Loring, M., ★1875
Lough, D. H., ★535
Loumos, S., 739
Lowenburg, H., ★1779
Lower, W. E., 576
Luccarelli, V., 257
Lucinesco, E., 2035
Lucksch, F., 1525
Ludwig, H., 1612
Lumière, A., 256
Lusskin, H., ★918
Lutz, W., 423
Luxenburger, H., 1773
Lynch, K. M., ★1818
Lyon, E. P., 1498

M

McAlpine, D., 500
MacBryde, C. M., 248
McCahey, J. F., 881
MacCallum, D., 1427
McCance, R. A., 2110
McClendon, J. F., 64
McCool, S. G., 155
McCord, C. P., ★913
McCorkle, J. H., 1128
McCullagh, D. R., 576
McDonald, H. P., 1220
McDonald, J. L., 741
McEachern, D., 157
McFetridge, E. M., 1766
McGavran, E. G., ★1781
McGehee, J. L., ★1163
McGowan, J. M., ★2227
McGrath, J. F., ★885
MacGuire, D. P., 422
Mach, R. S., 2035
Machacek, G. F., 418
McHenry, E. W., 2111
Machline, E., 165
McIntosh, R. L., 418
McKay, D. R., 1847
McKean, R. M., 324
McKeever, F. M., 2195
McKelvey, G. J., ★920
McKenzie, K. G., 2104
McKhann, C. F., 1422
McKinney, R. A., ★1660
McLane, C. M., 659
McLaughlin, R. F., 956
McLaughlin, R. R. M., 1605
MacLean, M. E., 1950
MacLeod, C. M., 880
MacLeod, G., 1043
McLester, J. S., ★373, ★1815, ★1865
McMillan, W. M., ★1791
Macnab, D. S., 497
McQuarrie, I., 1043
Macy, I. G., 574
Madden, E. E., 1753
Maddox, K., 1769
Madison, F. W., 412
Madsen, V., 1774
Maestrini, D., 1955
Magath, T. B., 246, 1338
Magnus, A. B., 1602
Maher, C. C., ★1546
Mainzer, F., 2205
Maitland, C. D., 1767
Major, R. H., 653
Maly, H. W., 159
Malzberg, B., 571
Man, E. B., 1603
Mandelbaum, H., ★1061
Mandelstamm, A., 964
Mandl, F., 581
Marble, A., ★24, ★180
Marchoux, E., 1047
Marfan, A. B., 1955
Marick, S. W., ★2238
Marks, M., 1689
Marks, M. B., 412, 1848
Marples, E., 879
Marriott, W. M., ★1442
Marsella, A., 1047
Marshall, L. H., 571
Marshall, V. F., 2108
Marshall, W., 2108
Martin, D. S., 334
Martin, K. A., ★1468
Martius, H., 1049
Maryan, H., 659
Marzetti, V., 501
Maseritz, I. H., 656
Masland, H. C., 234
Mason, J. T., ★1695, ★1817
Massell, B. F., 1679, 1847
Mateer, J. G., 570
Mathiasen, H., 1600
Matthew, G. D., 2200
Matvieeff, O. P., 1134
Matz, P. B., ★2214
Mawson, M. E. H., 2111
Maxted, W. R., 340
Mayer, L., 953
Mayer, O. B., ★2141
Mazzei, E. S., 1692
Meduna, K., 1048
Mees, R. A., 968
Mehlman, J., 334
Meigs, J. V., 1230
Melchior, E., 1433, 2115
Melli, G., 165
Melville, K. I., ★102
Mengle, H. A. K., ★1151
Menninger, W. C., ★756, 880
Menzies, E. C., 77
Merkelbach, O., 580
Merrell, P., ★665
Merritt, E. A., 2031
Merritt, H. H., ★1646
Merritt, K. K., 879
von Mészöly, P., 751
Metz, M. H., ★1658
Metzger, H. N., 2263
Metzger, I. D., 1207
Meulengracht, E., 660
Meyer, A., 2199
Meyer, O. O., 325
Meyer, R., 1615
Meyer, W. C., 1342
Meyerding, H. W., ★1139
Meyer-Heine, A., 2113
Meyler, L., 968
Michelson, H. E., 158
Mickle, F. L., 1762
Miller, D. K., 1849
Miller, E. M., ★2125
Miller, J. K., 1952, ★2059
Miller, J. R., ★616
Miller, L. F., 337
Miller, T. G., ★16
Mills, K. C., 1852
Minibeck, H., 1432
Minnich, W. C., 738
Mintz, E. R., 2109
Mirer, V. I., 504
Mishkind, D. I., ★1643
Mistal, O. M., 749, 1429
Mitchell, J. M., 329
Mitchell, L. A., ★450
Mitman, M., 1132
Möbius, W., 1862
Moehlig, R. C., 75
Møller, N. B., 344
Moeller, U., 2203
Mogensen, E., 1240
Moline, R., 81
Molitch, M., 573, ★1563, 2032
Mollard, H., 1235
Momigliano, E., 748
Money, R. A., 1046
Montgomery, T. L., 1229
Montpellier, J., 2266
Montu, E., 1041
Moolten, R. R., ★114
Moore, C., ★96
Moore, C. V., 325
Moore, J. E., ★115, ★464, 569
Moore, R. L., 417
Moore, S., ★906
Moorehead, M. T., ★373
Morgan, A. C., 1571
Morgan, B. G. E., 660
Morgan, C. N., 255
Morgan, H. W., ★1164
Mortillaro, M., 2105
Moskop, M., 951
Motley, E. P., 1038
Motley, L., ★898, ★1163
Mouzakeotis, T. C., ★1359
Mudd, S., ★890
Mühlbock, O., 581
Mühlfelder, W., 965
Müller, W., 750
Mullins, C. R., 77, 1045
Mura, V., 165
Murphy, D. P., ★457
Murphy, F. D., 245
Murphy, J. L., 1221
Murphy, J. M., 75
Murphy, W. P., 2089
Murray, J. M., ★282
Murray-Lyon, R. M., 1767
Muscovitz, A. N., ★1888
Mutch, N., 1858
Myers, G. B., 324
Myerson, A., 1599
Myerson, M. C., 1040

N

Naegeli, O., 1613
Naegeli, T., 2114
Naish, A. E., 2034
Napalkow, P. N., 1955
Napier, L. E., 2200
Nathanson, L., 1767
Nathanson, M. H., 314, 324
Natin, I., 883
Neale, A. V., 1609
Needles, J. H., 496
Needles, R. J., 955
Neff, F. C., 1604
Nekula, J., 1239
Nelson, M., 739
Nelson, N. A., ★105, ★115
Nelson, O. A., ★1005
Nemir, R. L., 2261
Netherton, E. W., 1039
Netzer, S., 1849
Neumann, H. O., 1136
Neuweiler, W., 582
Nevin, S., 1770
Newell, R. R., 738
Newman, H., ★595
Newton, A., 1954
Nicholls, E. E., 1338
Nicholls, J. B., 1607
Niedhold, C. D., 2108
Nigg, C., 334
Nikolajew, A. P., 84
Nishnevich, M. Y., 1050
Nissen, H. A., 420
Nissen, R., 167
Nissler, C. W., 417
Nobécourt, P., 256
Noble, J. F., 2106
Nocht, B., 499
Nonnenbruch, W., 580
Noonan, W. J., 325
von Noorden, W., 2036
Nuvoli, I., 1525
Nye, R. N., ★1075, 1765
Nyström, G., 420
Nyström, T. G., 426

O

Oberst, F. W., 1037
Ochsner, A., 1425, 1522
O'Connor, F. W., 329
Oefelein, F., 1862
Øilgaard, E., 2116
O'Flynn, E. G., 2109
Ogata, T., 657
Ohlmacher, A. P., ★2053
Ohlsen, A. S., 344
Ohshima, K., 2204
Okamura, D., 2204
Okinaka, S., 2204
Okunj, N., 662
O'Leary, P. A., ★464
Olmsted, W. H., 412
Olsen, A., 1616
Olsen, H. A., 586
Olsho, S. L., ★115
Olson, E. C., 1040
Oppenheim, M., 1137
Oppenheimer, E. H., 251
Orgain, E. S., 1763
Ormond, A. P., ★1726
Ormsby, O. S., ★1241
Ornstein, G. G., 2262
Orr, J. B., 1132
Orr, T. G., 336
Osborn, H. A., 2199
Osgood, E. E., 159, ★1888
O'Shaughnessy, L., 2201, 2262
Osman, A. A., 2200
Osterberg, A. E., ★1701
Osterhagen, H. F., 416
Ott, M. D., 2032
Otten, R. E., 1037
Otto, H., 584, 1771
Overholt, R. H., 1044
Owen, S. E., 1419

P

Pack, G. T., 332, 1419
Padget, P., 569
Pagel, W., 1427, 2201

Paggi, B., 1611
Pal, J., 1137
Palmer, W. L., 327
Pañganiban, C., 1855
Parade, G. W., 82
Pardo-Castello, V., 740
Pariente, A. C., ★1975
Park, E. A., 574
Park, W. H., 2261
Parker, F., Jr., 1037
Parker, F. P., 1422
Parmelee, A. H., 495
Parran, T., Jr., ★464
Parrish, P., 74
Parrot, J., 962
Pasricha, C. L., 2109
Patek, A. J., Jr., ★1463
Patterson, H. A., 337
Pattison, A. C., 1763
Paul, W. D., 332
Paulsen, F., 1434
Pavel, I., 967
Payne, W. W., 746, 1769
Pearse, H. E., Jr., 569
Peck, S. M., ★1783
Peckham, C. H., 953
Peczenik, O., 1862
Pelouze, P. S., ★115
Pendergrass, E. P., 1038
Penfield, W., 655
Pennetti, G., 1342, 1611
Pepper, D. S., ★890
Pepper, O. H. P., 1038
Peralta Ramos, A. G., 1525
Perchik, P. M., 259
Perez, B. B., 2197
Perkins, O. C., 2262
Perlès, S. (Mme.), 1341
Perley, A. M., 416
Perry, C. A., 252
Perry, C. B., 1133
Pershina, N. F., 1774
Peskind, S., 483
Petersen, M. C., ★775
Peterson, W. H., 574
Petri, S., 344
Pettit, A. V., 960
Pettit, H., ★890
Pfahler, G. E., 654
Pfanner, W., 2267
Pfau, C. L., ★1644; (correction) 2015
Pheasant, H. C., 741
Phipps, C., ★761
Piasecka-Zeyland, E., 2112
Pierce, S. N., 1856
Pierson, P. H., 738
Pigott, A. W., 573, 1523
Pilcher, C., 1690
Pilcher, F., Jr., 376
Pines, I., 425
Pinkham, C. B., 1571
Pirie, A. H., 1602
Pitkin, H. C., 741
Pizzillo, G., 335
Plass, E. D., 1037
Platter, H. M., 1571
Plewes, F. B., 2101
Poer, D. H., ★665
Pötzl, O., 2267
Polack, E., 1958
Polak, I. B., 163
Poliakoff, S., 2032
Politzer, G., 967
Pollack, H., 332
Pollock, L. J., ★350
Polsky, M., 657
Pommerenke, W. T., ★1654
Pontius, J. R., 416
Pool, J. L., 954
Popesco, M., 2113
Popow, A., 748
Popp, W. C., ★690
Porkhovnik, J., 1525
Porter, L., 1318
Porter, W. B., ★992
Posatti, F., 1863
Potter, M. G., ★1070
Poult, J., 256
Power, M. H., 2192
Powers, J. H., 1125
Preu, P. W., 572
Pribram, B. O., 168
Price, A. E., ★1631
Priesel, R., 1430, 1860
Prindle, K., ★1090
Prinzmetal, M., 742, 1229
Pryor, H. B., 959, 1600
Püschel, J., 1772
Pulvertaft, R. J. V., 748, 1042
Puppel, I. D., 329
Pusitz, M. E., 1851
Putnam, T. J., 655
Pytel, A. Y., 1615

Q

Quackenbush, F. W., 574
Quaglia, F., 1692
Quick, A. J., 871
Quimby, E. H., 332
Quinan, C., 419
Quoc Queyn, N., 501

R

Raab, A. P., ★1705
Raab, W., 664
Raaf, J., ★916
Rabinowitz, M. A., 1421, ★1705
Rackemann, F. M., ★976
Radvan, I., 967
Ræder, G., 1240
Rafsky, H. A., 1421
Raices, A. E., 964
Raisbeck, M. J., 1513
Rake, G., 1764
Ralli, E. P., ★1975
Ramirez, M. A., ★281
Ramsdell, E. G., 254
Randall, A., 1339
Randall, L. O., 1231
Ransohoff, N. S., 953
Rao, G. R., 1768
Rappaport, B., ★1076
Rasmussen, R., 2196
Rathbone, R. R., 2031
Rathe, H. W., 332
Ratner, H. S. V., 2031
Rattner, H., ★2230
Raue, F., 751
Ray, T. W., 160
Rector, J. M., 73
Redding, L. G., 499
Redowitz, E., 162
Reed, C. B., 1204
Reforzo Membrives, J., 1135
Regele, H., 1614, 1956
Reichel, H., 258
Reichert, F. L., 574
Reid, M. R., ★665
Reid, W. D., 1221, 1513
Reifenstein, E. C., 2192
Reifenstein, E. C., Jr., 2192
Reimann, H. A., 234, 955
Reinhard, F. O., ★1377
Reitzel, R. J., ★1090, ★1557
Repetto, E., 2203
Reuter, A., 1956
Reynolds, L., 75
Reznitskaya, E. Y., 1050
Rhoads, C. P., 1849
Riba, L. W., ★1971
Rice, J. C., 1951
Rich, M. L., 1765
Richards, O. W., 155
Richardson, E. C., ★1543
Richieri, A., 424, 1342
Rider, T. H., ★452
Ridout, J. H., 2111
Rieckhoff, W., 664
Rienhoff, W. F., Jr., 574
Rigler, L. G., 336, 1522
Riley, H. A., 1232
Riley, R. H., ★1438
Rinehart, J. F., 157
Ripps, M. L., 575
Risi, A., 169
Ritter, 883
Rivers, T. M., 1603
Roberts, L. J., ★1459
Robertson, E. C., 1232
Robertson, J., ★2133
Robertson, O. H., 742
Robins, S. A., 74, 1953
Robinson, C. C., 419
Robinson, G. H., 158
Robscheit-Robbins, F. S., 653
Roccas, L., 423
Rockstroh, H., 1615
Rodman, J. S., 1395
Rodriguez Olleros, A., 341
Rodríguez Pastor, J., 2034
Røvig, G., 84
Roffo, A. E., Jr., 166
Roffo, A. H., 166, 2111
Rogoff, J. M., ★279, 1690, 1753
Rohdenburg, G. L., 1421
Rohmer, P., 256
Roller, D., 1614
Romanis, W. H. C., 882
Ronzoni, E., 324
Roome, N. W., ★1885
Root, H. F., ★180, 1039
Rosahn, P. D., 1688
Rose, E., 1852
Rose, J., 966
Rose, M. S., 1043
Rosedale, R. S., 1847
Rosegger, H., 1137, 1236
Rosen, S., 1040
Rosenak, B. D., ★1
Rosenbaum, H. A., 575
Rosenbaum, M., ★1646
Rosenberg, D. H., ★1156
Rosenblate, A. J., ★1797
Rosenblatt, M. B., 2177
Rosenbliett, S., ★678
Rosenblum, A. H., ★988
Rosenblum, S. H., 739
Rosenfeld, S., 329
Rosenhagen, H., 662
Rosenthal, D. B., 1608
Rosenthal, N., ★1783
Rosenzweig, S., ★1660
Ross, J. R., 1127
Rosser, C., ★109
Rossiyskiy, D. M., 426
Rostock, P., 1773
Roth, E., 585
Roth, F., 342
Roth, G. M., 326, 2193
Rothenberg, R. E., ★1978
Rothström, G. E. A., 1434
Roussy, G., 501
Routley, T. C., ★1907
Rowe, A. W., 747
Rowe, S. N., 2103
Rowland, V. C., 1338
Rowntree, L. G., ★370
Roy, A. N., 1859
Roy, A. T., 1768
Rozental, Y. P., 752
Rubenfeld, S., 1424
Rubinstein, J. E., 1949
Ruckensteiner, E., 1048
Rucker, P., 1131
Ruiz Cestero, G., 2034
Runeberg, B., 1434
Russell, W. R., 2202
Ryder, C. F., ★512
Rydin, H., 170
Rykert, H. E., 1602
Rypins, H., 1395
Ryss, S. M., 1694

S

von Saalfeld, E., 422
Sabadini, L., 2266
Sacharov, G. P., 426
Sachs, E., 1854, 1949
Säfwenberg, O., 968
Salcedo-Salgar, J., 569
Salén, E. B., 260, 260
Salkin, D., 2102
Salmon, L. A., 1232
Sanders, C. E., ★916
Sandweiss, D. J., ★1452
Sanford, A. H., 1044
Santillan, J., 2197
Saperstein, A. N., ★1061
Saphir, O., ★902
Sappington, S. W., 1123
Sarroste, 580
Sasaki, M., 1429
Satanowsky, S., 1771
Sawers, W. C., 255
Sawizki, W., 259
Saxl, O., 583
Sayad, W. Y., ★461
Scammon, R. E., 1316
Scarlett, E. P., 497
Schaanning, C. K., 170
Schächter, F., 967
Schäfer, A., 1861
Schaffhauser, F., 1048
Schairer, E., 425
Schall, L. A., 251
Schally, A., 424
Scharff, I., 1773
Scharnagel, I. M., 332
Scheer, P., 1237
Scherer, H. J., 661
Schiller, W., 965
Schilling, V., 1238
Schlegel, M., 1238
Schlesinger, B., 746
Schliephake, E., 1956
Schloss, O. M., 1025
Schmidt-Lange, W., 1433
Schmitz, H. E., 1229
Schmorell, H., 169
Schmulovitz, M. J., 335
Schneider, 883
Schneiderbaur, A., 168
Schneiders, E. F., 1761
Schöller, R., 1773
Schönberg, H., 1860
Schöne, G., 258
Schönenberg, A., 82
Schöner, O., 1864
Schoenfeld, H. H., ★96
Scholl, A. J., ★701
Scholtz, H. G., 1772
Schott, E., 342
Schour, I., 1690
Schrader, R., 81
Schreuder, O. B., 1522
Schrock, R. D., ★1882
Schteingart, M., 1430
Schüle, F., 502
Schulten, H., 2204, 2267
Schultz, A., 1600
Schultz, A. A., 497
Schultzer, P., 1138
Schumacher, P. H., 168
Schutz, C. B., 958
Schwab, E. H., 2107
Schwanke, W., 967
Schwartz, A. L., ★1445, 1513
Schwartz, F. F., 871
Schwartz, W. F., ★2130
Schwedel, J. B., 1947
Sciclounoff, P., 2035
Scott, A. J., Jr., 879
Scott, G. L., 1954
Scott, G. M., 1428
Scott, J. C., 2191
Scott, S. G., 1858
Scott, T. F. M., 1603
Scott, W. G., ★906
Scoular, F. I., 2196
Scowen, E. F., 962
Seckel, H., 425
Seckinger, D. L., 250
Seegal, B. C., 334
Seeger, 883
Segal, M. S., 1947
Selesnick, S., 1220
Selinger, E., 740
Selter, H., 585
Semelaigne, G., 495
Semenov, H., 161
Semrad, E. V., 1523
Senear, F. E., 1044
Serény, B., 2114
Service, W. C., 741
Settle, R. O., ★1801
Seyfried, H., 663
Seymour, F. I., ★1728
Sézary, A., 501
Shafer, R. J., ★699
Shafiroff, B. J. P., ★779
Shafroth, W., ★1916
Shambaugh, G. E., Jr., 1421
Shannon, E. H., ★599
Shannon, J. G., 1601
Shapiro, H. H., ★434
Sharkey, T. P., 1039
Sharpe, J. C., ★682
Shaughnessy, T. J., ★669
Shaw, C. (Chicago), 954
Shaw, C. (London), 882
Shaw, E. C., 1853
Sheppe, W. M., 659
Sherman, W. B., ★284
Sheynbaum, N. M., 1433
Shibley, G. S., 324
Shilling, C. W., 163
Shillito, F. H., ★669
Shimamoto, T., 2204
Shookhoff, C., 1421
Short, J. J., ★1776
Shpolyanskiy, G. M., 169
Shrader, E. L., 324
Shumacker, H. B., Jr., 78
Shumaker, P., 960
Shurly, B. R., ★297
Shute, E., 747, 1768
Shwartzman, G., 2193
Siegel, I. A., 249
Siegel, M., 331
Siegl, J., 1430
Signorelli, J., 336
Sigoloff, E., ★1644; (correction) 2015
Silwer, H., 1958
Simici, D., 2113
Simon, B., 419
Simon, F. A., ★512
Simon, J. F., 1042
Simpson, S. L., 2196
Simpson, W. M., 246, 1044, 2104
Sinelnikov, S. N., 259
Singer, B., 331
Singleton, A. C., 1605
Siris, I. E., 739
Sise, L. F., 144
Sittler, W. W., ★1546
Skoog, T., 1616
Skutta, A., 1236
Slavin, P., 331
Sleeth, C. K., ★535
Slivko, I. W., 260
Sloan, L. L., 1947
Slo-Bodkin, S. G., ★678
Smith, C. D., ★1248
Smith, C. H., 559
Smith, F. J., 326
Smith, F. M., 332
Smith, G., 1691
Smith, G. V., 2106
Smith, J. C., 1616
Smith, J. F., 1857
Smith, O. N., 329
Smith, Rachel M., ★24
Smith, Richard M., 160
Smith, S. G., 252
Smith, W., 960
Smith, W. J., 2193
Snell, A. M., 414
Snow, W. F., ★115
Snyder, M., 2033
Sokoloff, M. J., 417
Solomon, H. C., ★1527
Solomon, P., 419
Soloway, D., 881
Soltz, S. E., 1232
Sones, C. A., 1232
Sonnauer, P., 1860
Sontag, L. W., 1848
Soto-Hall, R., 338
Sox, H. C., ★777
Spector, S. A., 884
Spence, A. W., 962
Spence, H. M., 498
Spence, K. W., 2199
Sperling, L., 655
Sperti, G., ★452
Spies, T. D., 78
Spitzer, M., 83
Sprague, R. G., ★1701
Sprunt, D. H., 252, ★1078
Squier, T. L., 412
Starcke, H., 1861
Starr, P., 248
Starr, S., 74
Startz, I. H., 745
Starz, W., 884
Steck, H., 963
Steele, J. M., ★2049
Steenbock, H., 574, 574, 1761
Steinach, E., 1862
Steinberg, A., ★370
Steinberg, U., 585
Steinbrocker, O., ★1448
Steinel, C., 81
Steiner, M., 1767
Steinert, R., 426
Steinkamm, E., 1526
Stephens, D. J., 880, 1604
Stern, R. O., 2265
Stevens, W. E., ★89, 1128
Stevenson, E. M., 333
Stewart, F. W., 1419, ★1802
Stewart, G. E., 325
Stiefler, G., 750
Stocker, F., 2113
Stokes, J. H., ★115, ★464, ★674
Stokes, J. S., ★780
Stoliarsky, R. G., 1849
Stone, W. S., 251
Storey, J. C., 1524
Stott, H., 500
Stotz, E. H., ★180
Stout, M. L., 953
Strandell, B., 1434
Strang, J. M., 1763
Straub, M. E., ★1448
Straus, H. W., 957
Strauss, A. A., ★285, ★1797
Strauss, I., 1949
Strauss, L. H., 1237
Strauss, M. B., ★1088
Strauss, M. J., ★517
Strömbeck, J. P., 170
Strømme, R., 1864
Stroykova, K. V., 1694
Strutz, H., 965
Stuart, R. D., 2111
Stuart-Harris, C. H.: See Harris, C. H. S.
Studley, H. O., ★458
Stürup, G., 1609
Stuhler, L. G., ★690
Stull, A., 419
Sugiura, K., 1419
Suk, V., 1331
Sullivan, A. J., 1423
Sullivan, R. R., 234
Sulzberger, M. B., 314, ★1000, 1041
Summerfeldt, P., 1127
Suntzeff, V., 951
Swartz, J. H., 1039
Sweany, H. C., ★1959
Sweet, M. H., 2105
Swift, G. W., 1425
Sykes, W. S., 1524
Sylvest, E., 2206
Symann, T., 1526
Szajna, M., 83

T

Tabor, F. S., 2196
Taggart, W. B., 1690
Tainter, M. L., 161, ★1386
Tamura, J. T., 959
Tanaka, T., 1419
Tannenbaum, W. J., ★1376
Tassovatz, B., 256
Tateno, S., 1771
Taub, S. J., 642, ★2144
Taylor, F., ★1144
Taylor, F. H. L., 159, 1123
Taylor, G. M., 740
Taylor, H., 2033
Taylor, H. C., Jr., 1045, 1606
Taylor, I., 1950
Taylor, S. G., III, 415
Templeton, H. J., 1689
Tennen, J. S., ★1711
Tennent, J. H., 2109
Tennent, T., 2199
Tenopyr, J., ★779
Terhune, S. R., 2261
Terplan, K. L., ★529
Teufl, R., 2267
Thannhauser, S. J., ★908
Thevarthundil, J., 1341
Thewlis, E. W., 325
Thomas, G. J., ★197
Thomas, J. E., ★507
Thomas, W. S., 1042
Thompson, G. J., 253, 576
Thompson, L. D., 324
Thompson, P. K., 415
Thompson, R. M., ★1869
Thompson, W. H., 1043

Thompson, W. O., 415
Thompson, W. P., 254
Thoms, H., ★1364
Thomson, E. F., 255
Thomson, S. C., 1234
Thomson, W., 1132
Thomson, W. A. R., 746
Thorek, M., 1950
Tiber, A. M., ★1537
Tislowitz, R., 167
Tocantins, L. M., 1039
Tolmach, J. A., 158
Tolstoi, E., 78
Tompkins, E. H., 953
Tompkins, P., 249
Toomey, J. A., 879, 1423
Torbert, H. C., ★683
Torkanovskiy, P. B., 260
Torrey, J. C., 1041
Touart, M. D., 1042
Townsend, J. H., 2106
Trapp, C. E., 1850
Trasoff, A., 1689
Traub, E. F., ★1711
Traut, H. F., 659
Treflov, V. S., 664
Trevett, L. D., 1042
Tripoli, C. J., ★171
Trostler, I. S., 1588
Trudeau, F. B., ★592
Tscherne, E., 2116
Tuck, V. L., 250
Tucker, W. L., 1042
Tumanskiy, V. K., 260
Tureen, L. L., ★1535
Turner, A. C., 500
Tuthill, C. R., 1850
Twinem, F. P., ★206
Tyson, T. L., 1764
Tzanck, A., 81

U

Ude, H., 2204
Ugarte, F., 81
Uhley, C. G., 742
Uhlmann, E., 1236
Ulesko-Stroganowa, 965
Ulrich, H., 1850
Ungley, C. C., 1954
Upham, J. H. J., ★1923
Uraguchi, K., ★1266
Urban, F. F., 748
Usilton, L. J., ★115, ★464

V

Vahlteich, E. M., 1043
Vajano, D., 661
Valdés Lambea, J., 661
Vallée, A., 1949
van Bogaert, A., 661
Van Buskirk, E. M., 2195
Van der Sande, D., 504
Van Donk, E. C., 1761
Van Etten, N. B., ★772, ★1814
Van Liere, E. J., ★535
Vanovskiy, V. R., 1240
Van Winkle, C. C., 159
Varićak, B., 1430
Vasudevan, A., 578
Vaughan, W. T., 1765
Velasco, F. I., 499
Velasco Suarez, C., 964
Venable, J. H., 1044
de Véricourt, R., 1860
Vézina, C., 1949
Vidal, C. B., 1951
Videla, C. A., 341
Vidgoff, B., 1850
Viethen, A., 583
Villaamil, R., 1855
Vinograd, J., 2261
Vinson, P. P., ★994
Vischer, A., 2266
Vlados, H., 1957
Vogl, A., 1137
Volgt, G., 1136
Volini, I. F., 956
Volovici, B., 967
Vonderahe, A. R., 1855
Vonderlehr, R. A., ★115, ★464, 1044
von Storch, T. J. C., 954
Vorlíček-Jelinek, M., 1614
Voskresenskiy, V. M., 1694
Vrtiak, E. G., ★1162; (correction) 1828
Vvedenskiy, V. I., 1694

W

Wachowski, T. J., ★596
Wachtel, H., 258
Wadsworth, A. B., 658
Wagner, D. H., ★587
Wahl, F. A., 1432
Wahlberg, J., ★1968
Wainwright, C. W., 1521
Wakerlin, G. E., 254
Waldorp, C. P., 1135
Walker, B. S., 2105
Walker, E. W., 2105
Walker, H., 1850
Walker, H. M., 2253
Walker, I. J., 1765
Walker, J. E., ★1795
Walker, M. A., ★1264
Wallace, C. E., ★1384
Wallace, R. F., 1848
Walsh, F. B., 1947
Walter, C. W., ★1982
Walters, W., 413, 1043, ★2227
Walton, H. J., 249
Warfield, L. M., ★892
Warwick, H. L., 939
Waters, E. T., 334
Waters, R. M., 739
Watkins, C. H., 326, 2107, 2193
Watson, C. M., ★520
Watson, E. M., 1126
Watson, J. R., ★520
Watts, J. W., 419
Wayne, E. J., 1954
Wear, J. B., 1767
Weber, F. P., 1859
Weber, M. L., 744
Weidman, F. D., 740
Weil, P. E., 1341
Weiland, P., 585
Weinholtz, G., 1135
Weinstein, G., 1852
Weintraub, W. L., 1124
Weisev, J., 580
Weisman, A. I., ★1643
Weiss, S., 159, 1765
Welch, C. E., 1953
Welch, H., 1762
Weller, G. L., Jr., 1231
Wells, A. H., ★1264
Wendeborn, H., 662
Wenusch, A., 1773
Werbatus, E., 581, 1773
Werner, A. A., ★1541
Werner, S. C., 955
West, W. K., 1130
von Westenrijk, N., 501
Weysser, C., 1957
Wheeldon, T. F., ★447
Wheeler, P., ★919
Whipple, G. H., 653, 653
White, P., ★180
White, P. D., 569, 1763
Whitman, A., ★112
Wichtl, O., 1239
Widdowson, E. M., 2110
Widmann, B. P., 330
Wieder, L. M., 418
Wiesner, B., 585
Wiesner, R., 1239
Wilbur, R. L., 1095
Wilcox, L. F., 330
Wildegans, H., 2204
Wilder, R. M., ★427, ★1701
Wile, U. J., ★115, ★464
Wilhelmy, E. W., 1339
Wilkinson, J. F., 1954
Willard, A. C., 1098
Willard, J. H., 2263
Willett, J. C., ★1644; (correction) 2015
Williams, D. H., ★1533
Williams, J. R., 2178
Williams, L. E., 159
Williams, R. D., 412
Williamson, G. M., 1393
Willimott, S. G., 1608
Willis, R. A., 2111
Willius, F. A., ★1890
Wilmoth, C. L., ★526
Wilson, C., 742
Wilson, C. W., 1427
Wilson, H., ★1885
Wilson, J. C., 2195
Wilson, S. J., 420
Wilson, W. D., ★2209
Wilson, W. M., 1426
Winslow, C.-E. A., 952
Wintrobe, M. M., 78, 1231
Wirkberg, R., 664
Wirtschafter, Z. T., ★1466
Wiseman, B. K., ★609
Witherspoon, J. T., 954
Wittenbourg, W., 1525
Witts, L. J., 1234
Wodstrup, I., ★177
Wohl, M. G., 575
Woldman, E. E., 1338
Wolf, G. D., 576
Wolff, L., 1763
Wolfson, W. L., ★1978
Wollstein, M., 2261
Wolpaw, S. E., 1847
Wood, C. B., 156
Wood, J. E., Jr., 1689
Wood, P., 1046
Wood, P. M., ★275
Wood, R. B., 338
Wood, W. S., 939
Woodall, P. S., 327
Woodburne, H. L., 570
Woodruff, G. H., ★1562
Woodruff, L. W., ★1544
Woodward, W. C., ★33, 1569, ★1896
Wootton, W. T., 740, 1854
Wortis, J., 2089
Wosika, P. H., 1421
Wright, C. S., ★1363, 1688
Wright, G. W., ★1804
Wright, H. D., 1428
Wright, L. T., ★1467
Wright, O. E., 2196
Wu, C. J., 1046
Wustmann, O., 167
Wylie, H. B., 335

Y

Yaskin, J. C., 1426
Yater, W. M., ★1625, 1849
Yatsevich, I. A., 260
Ying, S. H., 1524
Young, H. H., ★1800
Young, R. H., ★682
Yudin, S. S., ★997, 1137
Yudkin, A. M., 496
Yun, T. W., 1859

Z

Zabin, A., 1588
Zabusova, E. M., 84
Zakon, S. J., 642
Zeitlin, H., ★1057
Zeller, M., 956
Zentmire, Z., ★996
Zeyland, J., 2112
Zia, S. H., 1046
Zierold, A. A., 338
Zijlmans, A., 968
Zimin, A. N., 344
Zimmer, H., 258
Zimmerman, E. F., 2032
Zimmermann, M., 503
Zink, A., 1136
Zischinsky, H., 584
Zoefgen, W., 1957
Zondek, B., 423, ★1051, 2206
Zook, G. F., 1096
Zorina, V. V., 2116

INDEX TO PAGES

OF THE JOURNAL, ACCORDING TO WEEKLY ISSUES—VOLUME 106, JANUARY-JUNE, 1936

Pages	No.	Date	Pages	No.	Date	Pages	No.	Date	Pages	No.	Date
1— 84	1.....Jan. 4	587— 664	8.....Feb. 22	1241—1342	15.....April 11	1775—1864	21.....May 23
85— 170	2.....Jan. 11	665— 752	9.....Feb. 29	1343—1434	16.....April 18	1865—1958	22.....May 30
171— 260	3.....Jan. 18	753— 884	10.....March 7	1435—1526	17.....April 25	1959—2036	23.....June 6
261— 344	4.....Jan. 25	885— 968	11.....March 14	1527—1616	18.....May 2	2037—2116	24.....June 13
345— 426	5.....Feb. 1	969—1050	12.....March 21	1617—1694	19.....May 9	2117—2206	25.....June 20
427— 504	6.....Feb. 8	1051—1138	13.....March 28	1695—1774	20.....May 16	2207—2324	26.....June 27
505— 586	7.....Feb. 15	1139—1240	14.....April 4				

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